

ARH1.0001230098

**Name**

Mr. T RAVI

**Patient Identifier**

ARHIP55450

**Sex**

Male

**Date of Discharge  
MLC No**

21-Apr-2022

**Age**

40Yr 0Mth  
7Days

**Date of Admission**

20-Apr-2022

**Address**

GODAVARIKHANI,Karimnagar,Telangana

**Ward/Bed No**

First Floor,  
CICU ,  
Bed no:CICU11

**Primary Consultant Surgeons**

Dr. Vidya Sagar A--CARDIOLOGY

**Consultants**

**Anesthesiologists**

☐ **Diagnosis**

**Diagnosis**

Disease	Disease Type
.	

ACUTE INFERIOR WALL MIOCARDIAL INFARCTION WITH LOWER RESPIRATORY TRACT INFECTION

H.no 7-1-424

55455

ARH1.0001229  
981

**Patient Identifier** ARHIP55455

**Sex** Female

**Date of Discharge**  
**MLC No**

**Address** H.NO:18-4-  
198,MARUTHINAGAR,GODHAVARIKHANI,PEDDAPALLY,Other,Te  
langana

**Primary Consultant** Dr SOMASHEKAR K(MS

**Name** Mrs.  
KALAVATHI  
MADISHET  
TI

**Age** 71Yr  
0Mth  
11Day  
s

**Date of Admission** 21-  
Apr-  
2022

**Ward/ Bed No** First  
Floor,  
CT  
POST,  
Bed  
no:CT  
5

CORONARY ARTERY DISEASE, LMCA DISEASE+TVD+HYPOTHYROIDISM +S/P AWMI

SURGERY – EMERGENCY CORONARY ARTERY BYPASS GRAFTING [SVG TO LAD, OM, PLV]  
DONE ON 22/04/2022.

C/o retrosternal chest pain a/w sweating since 1 day

K/c/o HTN

ON ADMISSION VITAL

-----

Patient conscious, coherent

Afebrile

PR-80/min

BP-120/80mmhg

RR-18/min

RS-BAE+,  
CVS-S1S2+  
P/A-Soft,  
SPO2-98%

A 71 years old female patient Mrs. KALAVATHI MADISHETTI presented to hospital with c/o retrosternal chest pain a/w sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, LMCA DISEASE+TVD+HYPOTHYROIDISM +S/P AWM, SURGERY – EMERGENCY CORONARY ARTERY BYPASS GRAFTING [SVG TO LAD, OM, PLV] DONE ON 22/04/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, CONCENTRIC LVH, MILD MR, MODERATE TR/PAH, MILD LV SYSTOLIC DYSFUNCTION, NO PE/CLOT/VEG

BMI is 24.1 kg/m<sup>2</sup>.

Sr. Creatinine report on 23.04.2022 1.2 mg/dl.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. ND-VIT ONCE DAILY AT 2PM TO CONTINUE.
- 4) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.

- 5) TAB. THYRONORM 25 MCG TWICE DAILY AT 8AM 8PM BBF TO CONTINUE.
- 6) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.
- 7) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.
- 8) TAB. DOLO 650MG THRICE DAILY AT 8AM 2PM 8PM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD WITH TSH REPORT

ARH1.0001230331

**Name**

Mr.  
POCHAVENI  
RAJAM

**Patient Identifier** ARHIP55514

**Age** 60Yr  
0Mth  
1Days

**Sex** Male

**Date of Admission** 27-Apr-2022

**Date of Discharge**  
**MLC No**

**Address** thanagalapalli,Karimnagar,Telanganagana

**Ward/ Bed No** First Floor, CICU , Bed no:CICU10

**Primary Consultant** Dr. Vidya Sagar A--CARDIOLOGY

## ATRIOVENTRICULAR NODAL REENTRY TACHYCARDIA

R/F : ALCOHOL , DENOVO T2DM

CORONARY ANGIOGRAM (27/04/2022) -CAD-DVD (MODERATE LAD, RCA), LEFT DOMINANT SYSTEM

ADV: MEDICAL MANAGEMENT

C/o retrosternal chest pain a/w profuse sweating since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 65/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 60 years old male patient Mr. POCHAVENI RAJAM came with c/o retrosternal chest pain a/w profuse sweating since 1 day. All necessary investigations were done and diagnosed as **ATRIOVENTRICULAR NODAL REENTRY TACHYCARDIA**, R/F : ALCOHOL , DENOVO T2DM, CORONARY ANGIOGRAM (27/04/2022) -CAD-DVD (MODERATE LAD, RCA), LEFT DOMINANT SYSTEM, ADV: MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. STORVAS 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. DILZEM SR 90MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. CAVERYL 2 MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. GEMER 1 ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. NIKORAN 5 MG TWICE DAILY AT 8AM, 8PM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ADVISED TO CONSULTANT ELECTROPHYSIOLOGIST LATER

ARH1.0001230269

**Name**

Ms. LALITHA  
EDMALAPELLY

**Patient Identifier** ARHIP55501

**Age** 62Yr  
0Mth  
3Days

**Sex** Female

**Date of Admission** 25-Apr-2022

**Date of Discharge**  
**MLC No**

**Address** PURANI  
PET,Karimnagar,Telangana

**Ward/ Bed No** First  
Floor,  
CICU ,  
Bed  
no:CICU  
4

**Primary Consultant** Dr. Vidya Sagar A--  
CARDIOLOGY

CORONARY ARTERY DISEASE , ACUTE AWMi, NO TLT, SR

MILD LV SYSTOLIC DYSFUNCTION, EF-50%

CORONARY ANGIOGRAM DONE ON 27/04/2022 - CAD-SVD (LAD)

PLAN CABG WITH LIMA TO LAD.

R/F : T2DM, HTN

C/o chest pain since 3 days

At Admission

Afebrile

PR: 80/min

BP: 120/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-98%

A 62 years old female patient Ms. LALITHA EDMALAPALLY came with c/o chest pain since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , ACUTE AWTMI, NO TLT, SR, MILD LV SYSTOLIC DYSFUNCTION, EF- 50%, CORONARY ANGIOGRAM DONE ON 27/04/2022 - CAD-SVD (LAD), PLAN CABG WITH LIMA TO LAD. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. ZORYL MF2 850 MG ONCE DAILY AT 8 AM TO CONTINUE.
5. TAB. BETALOC 50 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS IN CARDIAC OPD WITH FBS, PLBS REPORTS



ARH1.0001229406

**Name**

Mr. PARAMKUSAM  
VENKATESHWARLU

**Patient Identifier** ARHIP55498

**Age** 58Yr  
0Mth  
30Days

**Sex** Male

**Date of Admission** 25-Apr-2022

**Date of Discharge**  
**MLC No**

**Address** laxmipur,Karimnagar,Telangana

**Ward/ Bed No** Second Floor, Semi Private, Bed no:118C

**Primary Consultant** Dr. Vidya Sagar A--  
CARDIOLOGY

ATYPICAL CHEST PAIN, SR

NORMAL LV SYSTOLIC FUNCTION

TMT POSITIVE (29/03/2022)

CORONARY ANGIOGRAM (28/04/2022) -MID LAD MILD DISEASE

ADV: MEDICAL MANAGEMENT

C/o chest pain since 3 months

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 72/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 58 years old male patient Mr. PARAMKUSAM VENKATESHWARLU came with c/o chest pain since 3 months. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN, SR, NORMAL LV SYSTOLIC FUNCTION, TMT POSITIVE (29/03/2022), CORONARY ANGIOGRAM (28/04/2022) -MID LAD MILD DISEASE, ADV: MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

#### DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. ATORVA 40MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 11 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001230280

**Name**

Mr.  
MALLESHAM  
KUSUMA

**Patient Identifier**

ARHIP55507

**Age**

83Yr  
0Mth  
2Days

**Sex**

Male

**Date of  
Admission**

26-Apr-  
2022

**Date of Discharge  
MLC No**

**Address**

siricilla,Karimnagar,Telanga  
na

**Ward/Bed  
No**

First  
Floor,  
MICU,  
Bed  
no:MIC  
U 4

**Primary Consultant**

Dr. RAMCHANDER TORREM

SEPSIS WITH MULTI-ORGAN FAILURE ON MECHANICAL VENTILATOR

Shortness of breath grade 3 to 4 on arrival  
Multiple episodes of loose stools since 1 day

Known case of ? hypertension and diabetic mellitus

AT ADMISSION:

Afebrile

PR: 110/min

BP: Not recordable

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 84%

P/A: Soft, BS+

Treated with

INJ.PAN  
INJ. HEPAMERZ  
INJ. KCL  
INJ.HUMAN ACTROPID  
INJ.REVSTER  
INJ.RENODEX  
INJ.ZENCSDT  
INJ.LEVIPIL  
INJ.GLUTAONE  
INJ.NOREDRENALINE  
INJ.METROGYL  
TAB CUDCE FORTE  
TAB KETOCHECK  
IV FLUIDS

A 83-year-old male patient <sup>MALLESHAM</sup> presented to the Emergency with complaints of shortness of breath grade 3 to 4, on arrival multiple episodes of loose stools since 1 day and altered sensorium for 6 hours, on arrival into ER patient BP was not recordable and connected to INJ. NORADRENALINE. Patient developed 1 episode of seizures, in view of poor GCS patient was intubated and connected to mechanical ventilator. Neurophysician consultation taken and advised followed. 2 cycles of renal replacement therapy (SLED) were done as patient has oligoanuria. All necessary investigations were done and diagnosed as Sepsis with multi-organ failure on mechanical ventilator. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA.

ARH1.0001230361

**Name**

Mr. K SAIKUMAR  
REDDY

**Patient Identifier**

ARHIP55523

**Age**

26Yr  
0Mth  
1Days

**Sex**

Male

**Date of  
Admission**

27-Apr-  
2022

**Expired Date**

28-Apr-2022

**MLC No**

**Address**

NARAYANAPUR KOHEDA  
SIDDIPET, Medak, Telangana

**Ward/Bed No**

First  
Floor,  
MICU,  
Bed  
no: MIC  
U 7

**Primary Consultant**

DR. SRI KARAN UDDESH --  
INTERNAL MEDICINE

**Consultants**

**Surgeons**

**Anesthesiologists**

Diagnosis

**Diagnosis**

Disease	Disease Type
	P

PARAQUAT POISONING, ACUTE KIDNEY INJURY.

Alleged history of consumption of paraquat poisoning around 400 ml at 4:30 p.m. on 27/04/2022  
C/o oral and throat ulcers , Shortness of breath, Irritability and pain abdomen

AT ADMISSION:

Patient tachypenic, obeys commands  
PR: 137/min

BP: 130/80 mmHg

RS: B/l lower lobe crackles

CVS: S1S2

RR: 20/min

SPO2: 96%

P/A: Soft, BS+

A 26 years old male patient Mr. K SAIKUMAR REDDY presented with above complaints. Patient presented with the above-mentioned complaints patient was immediately started on haemoperfusion for paraquat consumption. Patient was given INJ. SODIUM BICARBONATE patient was started on INJ. SODIUM BICARBONATE infusion patient condition was explained to the attenders. Patient was treated with INJ. DEXA INJ. Vitamin C INJ. GLUTATHIONE and IV fluids. on 28/04/2022 at 12.30 PM patient had sudden cardiac arrest, emergency intubation was done and connected to mechanical Ventilator support on SIMV mode with fio2-100%. CPR was initiated as per ACLS protocols, inspite of best effort return of spontaneous circulation could not be obtained, hence patient was declared as dead at 01.05 pm on 28/04/2022.

CAUSE OF DEATH

-----

SUDDEN CARDIOPULMONARY ARREST SECONDARY TO ARDS WITH PARAQUAT  
POISONING

## PatientDetails

**UHID** ARH1.0001229603  
**Patient Identifier** ARHIP55444  
**Sex** Female  
**Date of Discharge**  
**MLC No**  
**Address** ..Sircilla,Telangana  
**Primary Consultant** Dr SOMASHEKAR K(MS,

**Name** Mrs. D YELLAVVA  
**Age** 50Yr 0Mth 25Days  
**Date of Admission** 20-Apr-2022  
**Ward/Bed No** First Floor, CT POST, Bed no:CT 1

CORONARY ARTERY DISEASE+TVD+MYOCARDIAL ADHESIONS+S/P IWMI+HTN+  
HYPOTHYROIDISM, B/L PLEURAL ADHESIONS

SURGERY –CORONARY ARTERY BYPASS GRAFTING [SVG TO LAD, PDA]+ PERICARDIECTOMY  
DONE ON 25/04/2022.

C/o chest pain since 3 days.

ON ADMISSION VITAL

-----

Patient conscious, coherent

Afebrile

PR-82min

BP-110/70mmhg

RR-21/min

RS-BAE+,

CVS-S1S2+

P/A-Soft, BS+

SPO2-98%

A 50 years old female patient Mrs. D YELLAVVA presented to hospital with c/o chest pain since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE+TVD+MYOCARDIAL ADHESIONS +S/P IWMI+HTN+ HYPOTHYROIDISM, B/L PLEURAL ADHESIONS, SURGERY –CORONARY ARTERY BYPASS

GRAFTING [SVG TO LAD, PDA]+PERICARDIECTOMY DONE ON 25/04/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, GLOBAL HYPOKINESIA, MILD MR/TR/PAH, MODERATE LV DYSFUNCTION, NO PE/CLOT/VEG

BMI is 21 kg/m<sup>2</sup>.

Sr. Creatinine report on 26.04.2022 1.1 mg/dl.

DISCHARGE MEDICATION:

-----

- 1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. DYTOR 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. ND-VIT ONCE DAILY AT 2PM TO CONTINUE.
- 4) TAB. TELMA 20 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 6) TAB. THYRONORM 100 MCG ONCE DAILY AT 8AM TO CONTINUE.
- 7) TAB. CARDARONE 100 MG THRICE DAILY AT 8AM 2PM 8PM TO CONTINUE.
- 8) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.
- 9) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.
- 10) TAB. DOLO 650MG THRICE DAILY AT 8AM 2PM 8PM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD



ARH1.0001230278

**Name**

Mr. J  
MALLAIAH

**Patient Identifier**

ARHIP55508

**Age**

50Yr  
0Mth  
3Days

**Sex**

Male

**Date of  
Admission**

26-Apr-  
2022

**Date of Discharge  
MLC No**

**Address**

theegalaguttapally,Karimnagar,Telangana

**Ward/  
Bed No**

First  
Floor,  
CICU ,  
Bed  
no:CICU  
3

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

MODERATE LV SYSTOLIC DYSFUNCTION, EF-38%

R/F: HTN,DM

CORONARY ANGIOGRAM DONE ON 26/04/2022 - CAD-LM+SVD (LAD)

PRIMARY PTCA+DES TO LMCA, LAD WITH 3.5 X 19 MM METAFOR TO LAD, 4.0 X 13 MM METAFOR TO LMCA [LOT NO: MH11, S/N :CM19MH11016], [LOT NO: 5211889, S/N :05060127249091] DONE ON 26/04/2022.

C/o chest heaviness since 2 days

AT ADMISSION:

Afebrile

PR: 139/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 100%

P/A: Soft

A 50 years old male patient Mr. J MALLAIAH came with c/o chest heaviness since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWTMI, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-38%, R/F: HTN,DM, CORONARY ANGIOGRAM DONE ON 26/04/2022 - CAD-LM+SVD (LAD), PRIMARY PTCA+DES TO LMCA, LAD WITH 3.5 X 19 MM METAFOR TO LAD, 4.0 X 13 MM METAFOR TO LMCA DONE ON 26/04/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. TONACT 40MG ONCE DAILY AT 2PM TO CONTINUE.
- 4) TAB. BETALOC 25MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 5) TAB. PANTOCID 40MG ONCE DAILY AT 8AM FOR 10 DAYS
- 6) TAB. ZORYL M1 ONCE DAILY AT 8AM TO CONTINUE.
- 7) TAB. STAMLO 5 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

padmapanilws@gmail.com

ARH1.0001230229

<b>Name</b>	Mr. NARSAIAH TALLA		
<b>Patient Identifier</b>	ARHIP55488	<b>Age</b>	54Yr 0Mth 5Days
<b>Sex</b>	Male	<b>Date of Admission</b>	24-Apr-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	2-22, LALITHAPOOR,Karimnagar,Telangana	<b>Ward/ Bed No</b>	First Floor, CICU , Bed no:CICU1 1
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE AWMI,

MODERATE LV SYSTOLIC DYSFUNCTION, EF-45%

CORONARY ANGIOGRAM DONE ON 26/04/2022 - CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.0 X 20 MM METAFOR TO LAD [LOT NO: 24033502043A, S/N :22035203047] DONE ON 26/04/2022.

C/o chest pain since 4 days

AT ADMISSION:

Afebrile

PR: 86/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 54 years old male patient Mr. NARSAIAH TALLA came with c/o chest pain since 4 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, MODERATE LV SYSTOLIC DYSFUNCTION, EF-45%, CORONARY ANGIOGRAM DONE ON 26/04/2022 - CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.0 X 20 MM METAFOR TO LAD [LOT NO: 24033502043A, S/N :22035203047] DONE ON 26/04/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPITAB 75MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. CILODOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 5)TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001222014

**Name**

Mr. G MAHESH

**Patient Identifier**

ARHIP55495

**Age**

15Yr  
7Mth  
2Days

**Sex**

Male

**Date of Admission**

25-Apr-2022

**Date of Discharge  
MLC No**

**Address**

DURSHED,Karimnagar,Telangana

**Ward/  
Bed No**

First  
Floor,  
MICU,  
Bed  
no:MIC  
U 5

**Primary Consultant**

Dr. RAMCHANDER TORREM

INFECTIVE ENDOCARDITIS  
SEPTIC SHOCK  
CKD ON MHD

C/o 1 episode tonic clonic seizures  
Known case of CKD

AT ADMISSION:

Patient is irritable

PR: 98/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft



Treated with

INJ MEROPENUM EDTA

INJ ISEPAMICIN

INJ PANTAPRAZOLE

INJ ZOGER

INJ LEVOPIL

INJ VANCOMYCIN

TAB ECOSPRIN

A 15 years old male patient Mr. G MAHESH came with c/o 1 episode of tonic clonic seizures and fever, Known case of CKD on regular dialysis. Patient has multi access failure and taking dialysis through left femoral catheter done. Initially we suspected catheter related sepsis, on evaluation 2D echo revealed infective endocarditis. Patient required inotropic support, 4 cycles of renal replacement therapy done. MRI brain showed bilateral MCA infarcts. Neuro Physician Consultation Taken and advice followed. Patient referred to Higher Centre for CAPD .

DISCHARGE MEDICATION:

-----

1. TAB. ROXSAFE TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
2. TAB. SOBINIX DS TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
3. TAB. KETOCHECK TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
4. TAB. CUDCE TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
5. TAB. A TO Z GOLD ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. DYTOR 10 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
7. TAB. MONTAIR AB TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
8. TAB. ND Q10 ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 10 DAYS IN NEPHROLOGY OPD

ARH1.0001230272		<b>Name</b>	Mr. GANAPATHI DAGAM
<b>Patient Identifier</b>	ARHIP55505	<b>Age</b>	54Yr 0Mth 5Days
<b>Sex</b>	Male	<b>Date of Admission</b>	26-Apr-2022
<b>Date of Discharge MLC No</b>			
<b>Address</b>	REBBANA,KOMARAM BHEEM,Telangana	<b>Ward/ Bed No</b>	First Floor, CICU , Bed no:CICU 8
<b>Primary Consultant</b>	Dr. Vidya Sagar A-- CARDIOLOGY		
S			

CORONARY ARTERY DISEASE, NSTEMI, SR

MILD LV SYSTOLIC DYSFUNCTION, EF-45%

CORONARY ANGIOGRAM DONE ON 27/04/2022 - CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.0 X 13 MM METAFOR [LOT NO: MH32, S/N :CM13MH2047]  
DONE ON 27/04/2022

C/o chest pain a/w sweatings, SOB since 5 days

AT ADMISSION:

Afebrile

PR: 86/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 54years old male patient Mr. GANAPATHI DAGAM came with c/o chest pain a/w sweatings, SOB since 5 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-45%, CORONARY ANGIOGRAM DONE ON 27/04/2022 - CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.0 X 13 MM METAFOR [LOT NO: MH32, S/N :CM13MH2047] DONE ON 27/04/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASUDOC 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

////////

APH1.0001164249

**Name**

Mr. BODLA  
RAMULU

**Patient Identifier**

ARHIP55542

**Age** 74Yr  
2Mth  
25Days

**Sex**

Male

**Date of Admission** 29-Apr-2022

**Date of Discharge**  
**MLC No**

**Address**

8-7-  
90,KOTHIRANPUR,Karimnagar,Telangana

**Ward/Bed No** First  
Floor,  
CICU ,  
Bed  
no:CICU  
3

**Primary Consultant**

Dr. Vidya Sagar A--

ACUTE DECOMPENSATED HEART FAILURE  
ACUTE PULMONARY OEDEMA  
DRUG NONCOMPLAINT  
SEVERE LV SYSTOLIC DYSFUNCTION EF-27%  
S/P DCMF WITH SEVERE LV DYSFUNCTION EF-30%,SR WITH LBBB  
OPEN CHOLECYSTECTOMY 09/12/21

**C/o shortness of breath grade 2 to 3 since 3 days associated with mild cough**

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 120/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 74 years old male patient Mr. BODLA RAMULU came with c/o **shortness of breath grade 2 to 3 since 3 days associated with mild cough**. All necessary investigations were done and diagnosed as ACUTE DECOMPENSATED HEART FAILURE, ACUTE PULMONARY OEDEMA, DRUG NONCOMPLAINT, SEVERE LV SYSTOLIC DYSFUNCTION EF-27%, S/P DCMP WITH SEVERE LV DYSFUNCTION EF-30%,SR WITH LBBB, OPEN CHOLECYSTECTOMY 09/12/21. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. CLOPITAB 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. ATORVA 20MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. LANOXIN 0.25 MG ½ TAB ONCE DAILY AT 8AM TO CONTINUE 5/7.
4. TAB: CARDIVAS 3.125MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
5. TAB. PLANEP T 25/10 MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. VELOZ 20MG ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD



ARH1.0001230273

<b>Name</b>	Mr. LACHAIAH AMSHALA
<b>Patient Identifier</b>	ARHIP55504
<b>Sex</b>	Male
<b>Age</b>	47Yr 0Mth 5Days
<b>Date of Discharge</b>	
<b>MLC No</b>	
<b>Date of Admission</b>	25-Apr- 2022
<b>Address</b>	MALLAPUR,DHARMARAM,Other,Telangana
<b>Ward/ Bed No</b>	First Floor, CICU , Bed no:CICU12
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR  
SEVERE LV DYSFUNCTION [EF-25%]  
CORONARY ANGIOGRAM (28/04/2022) -CAD-SVD (LAD)  
PLAN PTCA+STENT TO LAD LATER

C/o chest pain since 2-3 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 47 years old male patient Mr. LACHAIAH AMSHALA came with c/o chest pain since 2-3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWTMI, NO TLT, SR, SEVERE LV DYSFUNCTION [EF-25%], CORONARY ANGIOGRAM (28/04/2022) -CAD-SVD (LAD), PLAN PTCA+STENT TO LAD LATER. Advised to get angioplasty done after fever has subsided, high risk explained to patient's family. Patient is being discharged in hemodynamically stable condition with required medication and advise.

#### DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPITAB 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. TONACT 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. BETALOC 25MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
5. TAB. FRUSELAC DS ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

#### LIFE STYLE MODIFICATION

ARH1.0001230329

<b>Name</b>	Mrs. SHIVARATRI SWAROOPA		
<b>Patient Identifier</b>	ARHIP55521	<b>Age</b>	42Yr 5Mth 3Days
<b>Sex</b>	Female	<b>Date of Admission</b>	27-Apr-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	14-4-538, VITTAL NAGAR, PEDDAPALLI, Karimnagar, Telangana	<b>Ward/ Bed No</b>	First Floor, CICU , Bed no: CICU13
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, NSTEMI, SR

NORMAL LV FUNCTION [EF-60%]

CORONARY ANGIOGRAM (30/04/2022) -NORMAL CORONARIES

PLAN MEDICAL MANAGEMENT

R/F : HTN, DM

C/o chest pain since 20 days back

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 80/min

BP: 140/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 42 years old male patient Mrs. SHIVARATRI SWAROOPA came with c/o chest pain since 20 days back. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, NORMAL LV FUNCTION [EF-60%], CORONARY ANGIOGRAM (30/04/2022) -NORMAL CORONARIES, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

#### DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPITAB 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. BETALOC 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB: RECLIMET ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0001230337

**Name**

Mr. N  
SATHYANARAYANA

**Patient  
Identifier**

ARHIP55520

**Age**

60Yr  
0Mth  
3Days

**Sex**

Male

**Date of  
Admission**

27-Apr-  
2022

**Date of  
Discharge  
MLC No**

**Address**

N T R Colony,Mancheria,Telangana

**Ward/  
Bed No**

First  
Floor,  
CICU ,  
Bed  
no:CICU  
2

**Primary  
Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, NSTEMI, SR

NORMAL LV FUNCTION [EF-60%]

CORONARY ANGIOGRAM (20/04/2022) -CAD-SVD [LAD]

MEDICAL MANAGEMENT FOR DIAGONAL [THIN VESSEL]

C/o chest pain a/w sweating since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 77/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 60 years old male patient Mr. N SATHYANARAYANA came with c/o chest pain a/w sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, NORMAL LV FUNCTION [EF-60%], CORONARY ANGIOGRAM (20/04/2022) -CAD-SVD [LAD], MEDICAL MANAGEMENT FOR DIAGONAL [THIN VESSEL]. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPITAB 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. METOLAR XR ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001230134

**Name**

Mr.  
RAJANNA D

**Patient Identifier**

ARHIP55464

**Age**

60Yr  
0Mth  
9Days

**Sex**

Male

**Date of  
Admission**

21-Apr-  
2022

**Date of Discharge  
MLC No**

**Address**

Other,Other

**Ward/  
Bed No**

First  
Floor,  
SICU,  
Bed  
no:SIC  
U 2

**Primary Consultant**

Dr. GOUTHAM ROY

PERFORATED JEJUNAL DIVERTICULAR DISEASE  
SURGERY: EXPLORATIVE LAPAROTOMY + JEJUNAL RESECTION, AND ANAESTHAMOSIS DONE ON  
23.04.2022

C/o pain abdomen since 7 days  
History of vomiting with mucous, contents food ,  
Nausea, fever +

PHYSICAL EXAMINATION:

ON ADMISSION

-----

Pt c/c/c

afebrile

PR-80/min

BP-120/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 60yr old male patient Mr. RAJANNA D came with c/o pain abdomen since 7 days, history of vomiting with mucous, contents food , Nausea, fever +. All necessary investigations done and diagnosed as PERFORATED JEJUNAL DIVERTICULAR DISEASE, SURGERY: EXPLORATIVE LAPAROTOMY + JEJUNAL RESECTION, AND ANAESTHAMOSIS DONE ON 23.04.2022. Findings: Multiple diverticulum noted in the jejunum involving in the entire length, Few diverticulum were perforated. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. TAB: SOMPRAZ-L TWICE DAILY AT 8AM, 8PM FOR 10 DAYS
5. SYP. LACTIHEP 15 ML ONCE DAILY AT 9 P.M.
6. SYP. SUCRAFIN 10 ML THRICE DAILY AT 8AM 2PM 8 P.M.
7. GLUTAVALT -V SACHETS ONCE DAILY AT 8AM WITH GLASS OF WATER FOR 15 DAYS.

Review after 10 days in General Surgery OPD.



ARH1.0001090717

**Patient Identifier** ARHIP55552

**Sex** Male

**Expired Date MLC No** 30-Apr-2022

**Address** VALLAMPLLY,MEDIPALLY,Karimnagar,Telangana

**Primary Consultant** Dr. RAMCHANDER TORREM(MD (General Medicine),DM Nephrology(NIMS),Associate Consultant-Nephrologist,Consultant Nephrologist)--NEPHROLOGY

**Surgeons**

**Name** Mr. MUKLA RAJENDRA PRASAD

**Age** 48Yr  
7Mth  
4Days

**Date of Admission** 29-Apr-2022

**Ward/Bed No** First Floor, MICU, Bed no:MICU 12

**Consultants**

**Anesthesiologists**

☐ **Diagnosis**

**Diagnosis**

**Add Diagnosis**

Disease	Disease Type
---------	--------------

PULMONARY EDEMA AND CKD (STAGE 5).

Patient brought to Emergency Room in gasping state for dialysis

AT ADMISSION:

Patient unconscious  
PR: 113/min

BP: 60/? mmHg

CVS: S1S2

SPO2: 50% mechanical ventilator on 100% FIO2

A 48 years old male patient Mr. MUKLA RAJENDRA PRASAD brought to Emergency Room in gasping state from dialysis patient was undergoing dialysis when he suddenly developed shortness of breath followed by altered sensorium leading to gasping, Patient was intubated and connected to mechanical ventilator support on SIMV mode with fio2-100%. CPR was initiated as per ACLS protocols, continued for 5 cycles but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 01.19 am on 30/04/2022.

#### CAUSE OF DEATH

-----

CARDIOPULMONARY ARREST SECONDARY TO PULMONARY EDEMA AND CKD (STAGE 5).

ARH1.0001230088

**Name**

Mrs. LAXMI  
D

**Patient Identifier**

ARHIP55506

**Age**

60Yr  
0Mth  
14Days

**Sex**

Female

**Date of Admission**

26-  
Apr-  
2022

**Date of Discharge  
MLC No**

**Address**

RAMAKRISHNAPUR,,Mancherial,Telangana

**Ward/  
Bed No**

First  
Floor,  
CT  
POST,  
Bed  
no:CT  
4

**Primary Consultant**

Dr SOMASHEKAR K(MS,MCH

CORONARY ARTERY DISEASE+TRIPLE VESSEL DISEASE+DIABETES MELLITUS+HYPERTENSION  
+S/P IWM

SURGERY – EMERGENCY CORONARY ARTERY BYPASS GRAFTING [SVG TO LAD, OM, PDA]  
DONE ON 30/04/2022.

C/o retrosternal chest pain a/w sweating since 2 days

ON ADMISSION VITAL

-----

Patient conscious, coherent

Afebrile

PR-80/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 60 years old female patient Mrs. LAXMI presented to hospital with c/o retrosternal chest pain a/w sweating since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE+TRIPLE VESSEL DISEASE+DIABETES MELLITUS+HYPERTENSION +S/P IWMI, SURGERY – EMERGENCY CORONARY ARTERY BYPASS GRAFTING [SVG TO LAD, OM, PDA] DONE ON 30/04/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, PARADOXICAL SEPTAL MOTION, MILD MR/TR/PAH, NORMAL LV SYSTOLIC FUNCTION. NO PE/CLOT/VEG

BMI is 20.3 kg/m<sup>2</sup>.

Sr. Creatinine report on 05.05.2022 1.7 mg/dl.

DISCHARGE MEDICATION:

-----

- 1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. ND-VIT ONCE DAILY AT 2PM TO CONTINUE.
- 4) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. MET-XL 25 MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
- 6) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.
- 7) TAB. DOLO 650MG THRICE DAILY AT 8AM 2PM 8PM FOR 5 DAYS.
- 8) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.
- 9) TAB. ALPRAX 0.25 MG ONCE DAILY AT 8PM FOR 5 DAYS.
- 6) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.

## REVIEW AFTER 11 DAYS TO CTVS OPD WITH FBS, PLBS REPORTS

ARH1.0001230023

**Name**

Mrs. SHAHEEN  
BEGUM

**Patient  
Identifier**

ARHIP55558

**Age**

40Yr 0Mth  
16Days

**Sex**

Female

**Date of  
Admission**

30-Apr-  
2022

**Date of  
Discharge  
MLC No**

30-Apr-2022

**Address**

.,Koratla,Telangana

**Ward/Bed No**

Ground  
Floor,  
Emergenc  
y Ward,  
Bed  
no:EME7

**Primary  
Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

**Consultants**

**Surgeons**

Dr. Vidya Sagar A--CARDIOLOGY

**Anesthesiologi  
sts**

Diagnosi  
S

**Diagnosis**

Disease	Disease Type
.	

CORONARY ARTERY DISEASE- UNSTABLE ANGINA.  
R/F:DIABETES MELLITUS.  
CORONARY ANGIOGRAM DONE ON 30/04/2022.  
IMP:NORMAL CORONARIES(MYOCARDIAL BRIDGING PRESENT)  
PLAN:MEDICAL MANAGEMENT

C/o vomiting 5-6 episodes since 2-3 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 85/min

BP: 80/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 40 years old female patient Mrs. SHAHEEN BEGUM came with c/o vomiting 5-6 episodes since 2-3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE- UNSTABLE ANGINA.

R/F:DIABETES MELLITUS, CORONARY ANGIOGRAM DONE ON 30/04/2022, NORMAL CORONARIES (MYOCARDIAL BRIDGING PRESENT), PLAN:MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

#### DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 75 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ROSUVAS 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. CONTINUE DIABETES MEDICATION

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001229598

**Patient Identifier**

ARHIP55559

**Sex**

Female

**Date of Discharge**

03-May-2022

**MLC No**

**Address**

SAIDAPUR,HUZURABAD,Karimnagar,Telangana

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

**Name**

Ms. MD SALMA

**Age**

45Yr 1Mth  
0Days

**Date of Admission**

30-Apr-2022

**Ward/Bed No**

First Floor,  
CICU ,  
Bed no:CICU10

**Consultants**

Surgeons

Anesthesiologists

Diagnosis

Diagnosis

Disease	Disease Type
CONTRAST INDUCED NEPHROPATHY METABOLIC ACIDOSIS, CAD ACUTE ANTERIOR WALL MYOCARDIAL INFARCTION,SR,NO,TLT, GLOBAL HYPOKALEMIA OF LV,SEVERE LV DYSFUNCTION EF-25% S/P CAG+PTCA+DES TO LAD DONE ON 6/4/22. R/F;HYPERTENSION DIABETIC MELLITUS RECENT CKD	

C/o shortness of breath grade-4 since 25 days associated with cough and sputum

AT ADMISSION:

Afebrile

PR: 98/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 25/min

SPO2: 97%

P/A: Soft

A 45 years old female patient <sup>MS. MD</sup> SALMA came with c/o shortness of breath grade-4 since 25 days associated with cough and sputum. All necessary investigations were done and diagnosed as CONTRAST INDUCED NEPHROPATHY METABOLIC ACIDOSIS, CAD ACUTE ANTERIOR WALL MYOCARDIAL INFARCTION,SR,NO,TLT, GLOBAL HYPOKALEMIA OF LV,SEVERE LV DYSFUNCTION EF-25%, S/P CAG+PTCA+DES TO LAD DONE ON 6/4/22, R/F;HYPERTENSION, DIABETIC MELLITUS, RECENT CKD. Nephrologist consultation taken and advice followed. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ROSEDAY 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. CONCOR 2.5 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. ALCYSTA ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. MONTAIR AB ONCE DAILY AT 8PM TO CONTINUE.
- 7) TAB. CUDCE TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 8) SYP. ASCORIL-LS 10 ml TWICE DAILY AT 8AM AND 8PM
- 9) TAB. FRUSELAC DS ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH RP-II, FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.



DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001230387

ARHIP55535

Mr. G VENU KUMAR | Male | 35Yr 0Mth 6Days

CVA-ACUTE INFARCT IN RIGHT MCA TERRITORY  
LEFT HEMIPARESIS  
T2DM  
? SEIZURES

C/o slurring of speech, sudden in onset of left sided weakness

AT ADMISSION:

Afebrile

PR: 84/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 35 years old male patient **Mr. G VENU KUMAR** came with c/o slurring of speech, sudden in onset of left sided weakness . All necessary investigations were done and diagnosed as CVA-ACUTE INFARCT IN RIGHT MCA TERRITORY, LEFT HEMIPARESIS, T2DM, ? SEIZURES. Managed conservatively. General physician consultation taken and advice followed. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB: ZORYL MV2 TWICE DAILY AT 8AM 8PM FOR 10DAYS.
2. TAB: DAPAGLYN 10MG ONCE DAILY AT 8AM FOR 10DAYS.
3. TAB: ECOSPRIN 150MG ONCE DAILY AT 8AM TO CONTINUE

4. TAB: ATORVASTATIN 40MG ONCE DAILY AT 8AM TO CONTINUE
5. TAB: TELMA 40MG ONCE DAILY AT 8AM TO CONTINUE
6. TAB: LEVIPIL 500MG ONCE DAILY AT 8AM TO CONTINUE
7. TAB: STAMLO 2.5 MG ONCE DAILY AT 8AM TO CONTINUE

REVIEW AFTER 11 DAYS IN DR. NIKHIL GOLI sir OPD.

ARH1.0001230069

	<b>Name</b>	Mrs. RUKSANA BEGUM
<b>Patient Identifier</b>	ARHIP55475	<b>Age</b> 50Yr 0Mth 11Days
<b>Sex</b>	Female	<b>Date of Admission</b> 23-Apr-2022
<b>Expired Date</b>	01-May-2022	
<b>MLC No</b>		
<b>Address</b>	4-1-10 VANI NAGAR,Karimnagar,Telangana	<b>Ward/Bed No</b> First Floor, CT POST, Bed no:CT 3
<b>Primary Consultant</b>	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant-Cardio Thoracic & Vascular Surgeon)--C T SURGERY	<b>Consultants</b>
<b>Surgeons</b>	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant-Cardio Thoracic & Vascular Surgeon)--C T SURGERY	<b>Anesthesiologists</b> Dr. K.S.D.KRISHNA KIRAN-- ANAESTHESIOLOGY

## Diagnosis

### Diagnosis

Disease	Disease Type
CORONARY ARTERY DISEASE,DOUBLE VESSEL DISEASE,SEVERE LV DYSFUNCTION,HYPERTENTION,DIABETES MELLITUS, S/P CORONARY ARTERY BYPASS GRAFTING	

C/o chest pain since 3 days

AT ADMISSION:

PR: 89/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 50 years old female patient Mrs. RUKSANA BEGUM came with c/o chest pain since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE,DOUBLE VESSEL DISEASE,SEVERE LV DYSFUNCTION,HYPERTENTION,DIABETES MELLITUS, S/P CORONARY ARTERY BYPASS GRAFTING. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and inotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 03.00 AM on 01/05/2022.

## CAUSE OF DEATH

-----

CARDIOPULMONARY ARREST SECONDARY TO LOW CARDIAC OUTPUT FAILURE -S/P CABG

ARH1.0001230453

	Name	Mr. BAPU B		
Patient Identifier	ARHIP55560	Age	62Yr 0Mth 4Days	
Sex	Male	Date of Admission	30-Apr-2022	
Date of Discharge	03-May-2022			
MLC No				
Address	REBBENA, ASIFABAD. 8019673105,Telangana	Ward/Bed No	CICU , CICU , Bed no:CICU1 1	
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY	Consultants		
Surgeons	Dr. Vidya Sagar A--CARDIOLOGY	Anesthesiologists		

Diagnosis

## Diagnosis

Disease	Disease Type
---------	--------------

CAD NON ST ELEVATION MYOCARDIAL INFARCTION,SR,NO TLT,MILD MR,MILD LV DYSFUNCTION,EF-46%  
CORONARY ANGIOGRAM DONE ON 30/04/22  
PRIMARY PTCA+DES TO LAD(XIENCE XPEDITION 3X18MM) DONE ON 30/04/2022.  
R/F;HYPERTENSION  
DENOVA DIABETIC MILLITUS  
ALCOHOL.

C/o SOB on exertion, chest pain since 3 days

### AT ADMISSION:

Afebrile

PR: 79/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 62 years old male patient Mr. BAPU B came with c/o SOB on exertion, chest pain since 3 days. All necessary investigations were done and diagnosed as CAD NON ST ELEVATION MYOCARDIAL INFARCTION,SR,NO TLT,MILD MR,MILD LV DYSFUNCTION,EF-46%, CORONARY ANGIOGRAM DONE ON 30/04/22, PRIMARY PTCA+DES TO LAD(XIENCE XPEDITION 3X18MM) DONE ON 30/04/2022, R/F;HYPERTENSION, DENOVA DIABETIC MILLITUS, ALCOHOL. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ROZAVEL 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. TAZLOC BETA 50MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. TAZLOC H 40MG ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. VELOZ 20 MG ONCE DAILY AT 8AM TO CONTINUE.
- 7) LIFE STYLE MODIFICATIONS FOR DIABETES

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001230511

		<b>Name</b>	Mrs. MALYALA SAROJA	
<b>Patient Identifier</b>	ARHIP55578	<b>Age</b>	50Yr 0Mth 3Days	
<b>Sex</b>	Female	<b>Date of Admission</b>	03-May-2022	
<b>Date of Discharge</b>				
<b>MLC No</b>				
<b>Address</b>	H NO-26-380/1,HAMALIWADA,Mancheria,Telangana		<b>Ward/Bed No</b>	First Floor, CICU , Bed no:CICU 9
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY			

DCMP, MODERATE MR, SR, LBBB,

SEVERE LV SYSTOLIC DYSFUNCTION [EF-30%]

CORONARY ANGIOGRAM (04/05/2022) -NORMAL CORONARIES

PLAN MEDICAL MANAGEMENT

C/o SOB on exertion, dry cough since 7 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft



A 50 years old female patient Mrs. MALYALA SAROJA came with c/o SOB on exertion, dry cough since 7 days. All necessary investigations were done and diagnosed as DCMP, MODERATE MR, SR, LBBB, SEVERE LV SYSTOLIC DYSFUNCTION [EF-30%], CORONARY ANGIOGRAM (04/05/2022) -NORMAL CORONARIES, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. TONACT 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. CARDIVAS 6.25 MG TWICE DAILY AT 8AM, 8PM TO CONTINUE.
5. TAB. DYTOR PLUS 10MG ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001230446

**Name**

Mr.  
PULLUTI  
NARSAIAH

**Patient Identifier**

ARHIP55562

**Age**

54Yr  
3Mth  
5Days

**Sex**

Male

**Date of  
Admission**

30-Apr-  
2022

**Date of Discharge  
MLC No**

**Address**

6-3-12,  
DURGAMMAGADDHA, KARIMNAGAR, Karimnagar, Telang  
ana

**Ward/  
Bed No**

First  
Floor,  
CICU ,  
Bed  
no: CICU  
8

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR  
MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%

R/F: HYPERTENSION

CORONARY ANGIOGRAM DONE ON 02/05/2022 - CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.5 X 24 MM METAFOR DONE ON 02/05/2022

C/o left sided chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 54years old male patient Mr. PULLUTI NARSAIAH came with c/o left sided chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWTMI, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%, CORONARY ANGIOGRAM DONE ON 02/05/2022 - CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.5 X 24 MM METAFOR [LOT NO: MH30, S/N :CM24MH30071] DONE ON 02/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. CILODOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 4) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. EPTOIN 100 MG 2 TAB ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001230345

**Name**

Mr. K MADHAIAH

**Patient Identifier**

ARHIP55531

**Sex**

Male

**Date of Discharge  
MLC No**

**Address**

SATHARAM  
KORUTLA,Karimnagar,Telangana

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

**Age**

53Yr 0Mth  
8Days

**Date of Admission**

28-Apr-2022

**Ward/ Bed No**

First Floor,  
CICU ,  
Bed no:CICU13

CORONARY ARTERY DISEASE, NSTEMI, SR

MODERATE LV SYSTOLIC DYSFUNCTION [EF-40%]

R/F : HYPERTENSION, ALCOHOL, BRONCHIAL ASTHMA

CORONARY ANGIOGRAM (04/05/2022) -NORMAL CORONARIES

PLAN MEDICAL MANAGEMENT

C/o severe SOB grade-IV since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 53 years old male patient Mr. K MADHAIAH came with c/o severe SOB grade-IV since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, MODERATE LV SYSTOLIC DYSFUNCTION [EF-40%], R/F : HYPERTENSION, ALCOHOL, BRONCHIAL ASTHMA, CORONARY ANGIOGRAM (04/05/2022) -NORMAL CORONARIES, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN GOLD 10MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CARDIVAS 12.5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. FRUSELAC ONCE **IN A DAY AT 8 AM** TO CONTINUE.
4. TAB. LOSAR 50 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. VOBOSE 0.3 MG ONCE DAILY AT 2PM BEFORE LUNCH TO CONTINUE.
6. CAP. ABFLO 100 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001230465

<b>Name</b>	Mr. RAMAGIRI NAGESH		
<b>Patient Identifier</b>	ARHIP55569	<b>Age</b>	33Yr 0Mth 3Days
<b>Sex</b>	Male	<b>Date of Admission</b>	02-May-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	3- 69,peddampet,upparlakesaram,Karimnagar,Telangana	<b>Ward/ Bed No</b>	First Floor, CICU , Bed no:CICU 2
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, NSTEMI, SR

NORMAL LV FUNCTION, EF-60%

CORONARY ANGIOGRAM DONE ON 02/05/2022 - CAD-SVD (LCX)

PTCA+DES TO LCX WITH 2.75 X 19 MM METAFOR DONE ON 02/05/2022

C/o chest pain since 1 day a/w SOB, palpitations

AT ADMISSION:

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 33years old male patient Mr. RAMAGIRI NAGESH came with c/o chest pain since 1 day a/w SOB, palpitations. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, NORMAL LV FUNCTION, EF-60%, CORONARY ANGIOGRAM DONE ON 02/05/2022 - CAD-SVD (LCX), PTCA+DES TO LCX WITH 2.75 X 19 MM METAFOR [LOT NO: MG78, S/N :CM19MG78015] DONE ON 02/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASUDOC 10MG ONCE DAILY AT 8PM TO CONTINUE.
- 3) TAB. ROSUVAS 40MG ONCE DAILY AT 8AM TO CONTINUE.
- 4) SYP. POTKLOR 15 ml THRICE DAILY AT 8AM 2PM AND 8PM TO CONTINUE.
- 5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

LIFE STYLE MODIFICATIONS FOR DIABETES

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.



CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001230427

**Name**

Mrs. LAXMI B

**Patient Identifier**

ARHIP55557

**Sex**

Female

**Date of Discharge  
MLC No**

01-May-2022

**Address**

5-2/A 7  
EKLSAPUR,Karimnagar,Telangana

**Primary Consultant  
Surgeons**

Dr. Vidya Sagar A--CARDIOLOGY

**Age**

55Yr 0Mth  
7Days

**Date of Admission**

30-Apr-2022

**Ward/Bed No**

First Floor,  
CICU ,  
Bed no:CICU12

**Consultants  
Anesthesiologists**

☐ **Diagnosis**

**Diagnosis**

Disease	Disease Type
---------	--------------

CORONARY ARTERY DISEASE-ACUTE INFERIOR WALL MYOCARDIAL INFARCTION NO TLT, SR.SEVERE LV SYSTOLIC DYSFUNCTION EF:30%.

C/o chest pain a/w SOB since 4 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 100/min

BP: 100/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 55 years old female patient Mrs. LAXMI B came with c/o chest pain a/w SOB since 4 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SR, MILD LV DYSFUNCTION [EF-45%], R/F : ALCOHOLIC, CORONARY ANGIOGRAM (21/12/2021) -CAD-RCA mid moderate stenosis. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA.

ARH1.0001230325

Name

Mrs. VIJAYA  
DURISETTI

Patient  
Identifier

ARHIP55513

Age

54Yr  
0Mth  
9Days

Sex

Female

Date of  
Admission

27-Apr-  
2022

Date of  
Discharge  
MLC No

01-May-2022

Address

2-74  
BHEEMARAM,Karimnagar,Telangana

Ward/Bed No

First  
Floor,  
CICU ,  
Bed  
no:CICU  
1

Primary  
Consultant  
Surgeons

Dr. Vidya Sagar A--CARDIOLOGY

Consultants  
Anesthesiologi  
sts

Diagnosis  
S

Diagnosis

Disease	Disease Type
---------	--------------

CORONARY ARTERY DISEASE-ACUTE ANTERIOR WALL MYOCARDIAL INFARCTION WITH APICAL VENTRICULAR SEPTAL RUPTURE,MILD MR,SR.  
SEVERE LV SYSTOLIC DYSFUNCTION

C/o chest pain sudden onset, pain radiating to left arm a/w SOB

**AT ADMISSION:**

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 54 years old female patient Mrs. VIJAYA DURISETTI came with c/o chest pain sudden onset, pain radiating to left arm a/w SOB. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE-ACUTE ANTERIOR WALL MYOCARDIAL INFARCTION WITH APICAL VENTRICULAR SEPTAL RUPTURE,MILD MR,SR, SEVERE LV SYSTOLIC DYSFUNCTION. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA.

ARH1.0001230429

**Name**

Mr. R MALLAIAH

**Patient Identifier**

ARHIP55555

**Age**

62Yr  
0Mth  
6Days

**Sex**

Male

**Date of Admission**

30-Apr-2022

**Date of Discharge**

03-May-2022

**MLC No**

BHUPATHPUR,Karimnagar,Telangana

**Ward/Bed No**

First Floor,

CICU ,  
Bed  
no:CICU  
4

**Primary Consultant** Dr. Vidya Sagar A--CARDIOLOGY  
**Surgeons** Dr. Vidya Sagar A--CARDIOLOGY

**Consultants**  
**Anesthesiologists**

Diagnosis

Diagnosis

Disease	Disease Type
.	

CAD- ANTERIOR WALL MYOCARDIAL INFARCTION SR,NO TLT,MILD LV SYSTOLIC DYSFUNCTION,  
CORONARY ANGIOGRAM DONE ON 30/04/22.  
PRIMARY PTCA+DES TO LCX (3V ASTRA 2.75X16MM)  
PTCA+DES TO LAD(METAFOR 3X16MM DONE ON 30/04/22.  
R/F DIABETIC MELLITUS

C/o chest pain a/w vomiting since 2 days

AT ADMISSION:

Afebrile

PR: 84/min

BP: 140/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 62 years old male patient Mr. R MALLAIAH came with c/o chest pain a/w vomiting since 2 days. All necessary investigations were done and diagnosed as CAD- ANTERIOR WALL MYOCARDIAL INFARCTION SR,NO TLT,MILD LV SYSTOLIC DYSFUNCTION, CORONARY ANGIOGRAM DONE ON 30/04/22, PRIMARY PTCA+DES TO LCX (3V ASTRA 2.75X16MM), PTCA+DES TO LAD(METAFOR 3X16MM DONE ON 30/04/22.

R/F DIABETIC MELLITUS. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. CILODOC 50MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001230602

<b>Name</b>	Mrs. NOOKALA MALLU		
<b>Patient Identifier</b>	ARHIP55605	<b>Age</b>	65Yr 0Mth 1Days
<b>Sex</b>	Female	<b>Date of Admission</b>	06-May-2022
<b>Date of Discharge MLC No</b>			
<b>Address</b>	chennur,Mancherial,Telangana	<b>Ward/ Bed No</b>	First Floor, Day Care, Bed no:DC 3
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY		

ICMP, MODERATE MR, SR,

SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%

R/F HTN

CORONARY ANGIOGRAM DONE ON 06/05/2022 - CAD-TVD (LAD, LCX, RCA)

PLAN CABG.

C/o Retrosternal chest pain, radiating to the back since 2 days

At Admission

Afebrile

PR: 82/min

BP: 120/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-98%

A 65 years old female patient Mrs. NOOKALA MALLU came with c/o retrosternal chest pain, radiating to the back since 2 days. All necessary investigations were done and diagnosed as ICMP, MODERATE MR, SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%, R/F HTN, CORONARY ANGIOGRAM DONE ON 06/05/2022 - CAD-TVD (LAD, LCX, RCA), PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. BISOMAX L 2.5MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. ANGISPAN TR 2.5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. RABIFER 20 MG ONCE DAILY AT 8AM FOR 7 DAYS.

REVIEW AFTER 7 DAYS IN CARDIAC OPD



ARH1.0001230492

**Name**

Mr. B  
SRINIVAS

**Patient Identifier**

ARHIP55570

**Age** 55Yr 0Mth  
4Days

**Sex**

Male

**Date of Admission** 02-May-2022

**Date of Discharge**

**MLC No**

**Address**

Godavarikhani,  
peddapally,Karimnagar,Telangana

**Ward/  
Bed No** First  
Floor,  
CICU ,  
Bed  
no:CICU1  
2

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, AWTMI, NO TLT, KILLIPS CLASS-4,

SEVERE LV DYSFUNCTION, EF-30%

R/F: HYPERTENSION

CORONARY ANGIOGRAM DONE ON 02/05/2022 - CAD-SVD (LAD)

PRIMARY PTCA+DES TO LAD WITH 2.5 X 12 MM 3 V ASTRA DONE ON 02/05/2022  
CARDIOGENIC SHOCK RECOVERED

C/o chest pain since 1 day a/w mild cough

AT ADMISSION:

Afebrile

PR: 112/min

BP: 100/50mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 55years old male patient Mr. B SRINIVAS came with c/o chest pain since 1 day a/w mild cough. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWTMI, NO TLT, KILLIPS CLASS-4, SEVERE LV DYSFUNCTION, EF-30%, R/F: HYPERTENSION , CORONARY ANGIOGRAM DONE ON 02/05/2022 – CAD-SVD (LAD), PRIMARY PTCA+DES TO LAD WITH 2.5 X 12 MM 3 V ASTRA [LOT NO: 240335032043A, S/N :22035323036] DONE ON 02/05/2022, CARDIOGENIC SHOCK RECOVERED. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

Sujatha pedicse screw sunbrath

Raju pcnl sures

ARH1.0001230600

**Name**

Mr. M HARI SINGH

**Patient Identifier**

ARHIP55603

**Age**

46Yr  
0Mth  
1Days

**Sex**

Male

**Date of Admission**

05-May-2022

**Date of Discharge  
MLC No**

**Address**

CHINTHAKUNTA SIRPUR KHAGAZNAGAR  
KOMURAM  
BHEEM,Adilabad(Adilabad),Telangana

**Ward/  
Bed No**

First  
Floor,  
CICU ,  
Bed  
no:CICU  
8

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE IWMI, TRIVIAL MR, SR

MILD LV SYSTOLIC DYSFUNCTION [EF-50%]

TLT WITH TENECTOPLUS DONE ON 05/05/2022

R/F: HTN

CORONARY ANGIOGRAM (06/05/2022) -CAD-SVD (RCA)

ADV: PTCA+DES TO RCA

C/o chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft

A 46 years old male patient Mr. M HARI SINGH came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, TRIVIAL MR, SR, MILD LV SYSTOLIC DYSFUNCTION [EF-50%], R/F: HTN, CORONARY ANGIOGRAM (06/05/2022) -CAD-SVD (RCA), ADV: PTCA+DES TO RCA. PTCA abandoned as balloon could not be crossed over the lesion and referred to higher center for further management. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

ARH1.0001230530

**Name**

Mr. R VISHNU

**Patient Identifier**

ARHIP55586

**Sex**

Male

**Date of Discharge  
MLC No**

**Age**

36Yr 0Mth  
3Days

**Date of Admission**

04-May-2022

**Address**

SIRICILLA,Telangana

**Ward/  
Bed No**

First  
Floor,  
CICU ,  
Bed  
no:CICU1  
0

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

S

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

MODERATE LV DYSFUNCTION, EF-35%

CORONARY ANGIOGRAM DONE ON 04/05/2022 - CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.5 X 28 MM XIENCE XPEDITION DONE ON 04/05/2022  
R/F: DENOVO DIABETES

C/o chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 80/min

BP: 90/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 36 years old male patient <sup>Mr. R. VISHNU</sup> came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWTMI, NO TLT, SR, MODERATE LV DYSFUNCTION, EF-35%, CORONARY ANGIOGRAM DONE ON 04/05/2022 - CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.5 X 28 MM XIENCE XPEDITION DONE ON 04/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. AXCER 90MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. ROZAVEL 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. NEXPRO 20 MG ONCE DAILY AT 8AM TO CONTINUE.

#### LIFE STYLE MODIFICATIONS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.



ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001230522

**Name**

Mr. SHAIK  
MOHINODDIN

**Patient  
Identifier**

ARHIP55585

**Age**

42Yr  
0Mth  
3Days

**Sex**

Male

**Date of  
Admission**

04-May-  
2022

**Date of  
Discharge  
MLC No**

**Address**

KORUTLA,Karimnagar,Telangana

**Ward/Bed  
No**

First  
Floor,  
MICU,  
Bed  
no:MIC  
U 2

**Primary  
Consultant  
Surgeons**

Dr. Vidya Sagar A--CARDIOLOGY

**Consultants**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, AWTMI, SR, NO TLT,

MODERATE LV DYSFUNCTION, EF-35%

MILD TR/PAH/MR

CORONARY ANGIOGRAM DONE ON 04/05/2022 - CAD-SVD (LAD)

PRIMARY PTCA+DES TO LAD WITH 3.5 X 37 MM METAFOR DONE ON 04/05/2022  
R/F: T2DM

C/o Retrosternal chest pain, radiating to back since 1 day

AT ADMISSION:

Afebrile

PR: 86/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 42 years old male patient Mr. SHAIK MOHINODDIN came with c/o retrosternal chest pain, radiating to back since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWTMI, SR, NO TLT, MODERATE LV DYSFUNCTION, EF-35%, MILD TR/PAH/MR, CORONARY ANGIOGRAM DONE ON 04/05/2022 - CAD-SVD (LAD), PRIMARY PTCA+DES TO LAD WITH 3.5 X 37 MM METAFOR [LOT NO: MH22, S/N :CM37MH22001] DONE ON 04/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASUDOC 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ROSEDAY 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. BETALOC 25MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 5) TAB. GLYCOMET SR 500MG ONCE DAILY AT AFTER BREAKFAST TO CONTINUE.
- 6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

#### LIFE STYLE MODIFICATIONS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001081771

**Name**

Mr. K MALLAIAH

**Patient Identifier**

ARHIP55607

**Sex**

Male

**Date of Discharge  
MLC No**

**Address**

3-6-514,SUBASH  
NAGAR,Karimnagar,Telangana

**Primary Consultant**

Dr. GOUTHAM ROY (MS(General  
Surgery),Consultant

**Age**

52Yr 11Mth  
15Days

**Date of Admission**

06-May-  
2022

**Ward/  
Bed No**

First Floor,  
RECOVERY  
ROOM, Bed  
no:RR 1

GALLSTONE DISEASE

SURGERY: LAPROSCOPIC CHOLECYSTECTOMY DONE ON 06.05.2022

C/o pain abdomen since 5 days

PHYSICAL EXAMINATION:

ON ADMISSION

-----  
Pt c/c/c

afebrile

PR-82/min

BP-120/80mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 52 yr old male patient K. MALLAIAH came with c/o pain abdomen since 5 days. All necessary investigations done and diagnosed as GALLSTONE DISEASE, SURGERY: LAPROSCOPIC CHOLECYSTECTOMY DONE ON 06.05.2022. Findings: Well distended gallbladder with calot's. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. TAB: SOMPRAZ-L TWICE DAILY AT 8AM, 8PM FOR 15 DAYS

Review after 7 days in General Surgery OPD.

ARH1.0001230597

**Name**

Mr.  
CHELIMALLA  
MONDAIAH

**Patient Identifier**

ARHIP55598

**Age**

60Yr  
0Mth  
2Days

**Sex**

Male

**Date of Admission** 05-May-2022

**Date of Discharge**

**MLC No**

**Address**

INDIRANAGAR,Karimnagar,Telangana

**Ward/Bed No**

First  
Floor,  
CICU ,  
Bed  
no:CICU  
9

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%

CORONARY ANGIOGRAM DONE ON 05/05/2022 - CAD-DVD (RAMUS, LCX)

PTCA+DES TO RAMUS WITH 3.0 X 16 MM METAFOR, LCX WITH 3.5 X 13 MM METAFOR DONE ON 05/05/2022

R/F: T2DM

C/o chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 81/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 60 years old male patient Mr. CHELIMALLA MONDAIAH came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%, CORONARY ANGIOGRAM DONE ON 05/05/2022 – CAD-DVD (RAMUS, LCX), PTCA+DES TO RAMUS WITH 3.0 X 16 MM METAFOR, LCX WITH 3.5 X 13 MM METAFOR DONE ON 05/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. CILODOC 50MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. ROSEDAY 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. RECLIDE XR 60 MG ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.



CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001230587

**Name**

Mr.  
KARNALA  
GANGADAR

**Patient Identifier**

ARHIP55597

**Age**

24Yr  
0Mth  
2Days

**Sex**

Male

**Date of  
Admission**

05-May-  
2022

**Date of Discharge  
MLC No**

**Address**

ITIKYALA,JAGITYAL,Telangana

**Ward/  
Bed No**

First  
Floor,  
CICU ,  
Bed  
no:CICU  
4

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

MODERATE LV SYSTOLIC DYSFUNCTION, EF-45%

CORONARY ANGIOGRAM DONE ON 05/05/2022 – CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.5 X 23 MM PRONOVA CC DONE ON 05/05/2022  
R/F: ALCOHOLIC

C/o chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 107/min

BP: 100/50mmHg

RS: BAE+

CVS: S1S2+

RR: 22/min

SPO2: 99%

P/A: Soft

A 24 years old male patient Mr. KARNALA GANGADAR came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-45%, CORONARY ANGIOGRAM DONE ON 05/05/2022 – CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.5 X 23 MM PRONOVA CC DONE ON 05/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. NOVASTAT 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. BETALOC 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001230521

**Name**

Mr. MOHD  
GOUSIDDUN

**Patient Identifier**

ARHIP55584

**Age** 83Yr 0Mth  
4Days

**Sex**

Male

**Date of Admission** 04-May-  
2022

**Date of Discharge**

**MLC No**

**Address**

6-2-39,  
Bendapelly,Karimnagar,Telangana

**Ward/Bed No** First Floor,  
RECOVERY  
ROOM, Bed  
no:RR 3

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE IWMI,

MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%

CORONARY ANGIOGRAM DONE ON 05/05/2022 - CAD-TVD (LAD, LCX, RCA)

PRIMARY PTCA+DES TO RCA WITH 3.5 X 40 MM METAFOR DONE ON 04/05/2022  
(CABG LATER)

R/F: HTN

C/o chest pain a/w SOB since 4 days

AT ADMISSION:

Afebrile

PR: 78/min

BP: 100/50mmHg

RS: BAE+

CVS: S1S2+

RR: 22/min

SPO2: 99%

P/A: Soft

A 83 years old male patient Mr. MOHD GOUSIDDUN came with c/o chest pain a/w SOB since 4 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%, CORONARY ANGIOGRAM DONE ON 05/05/2022 – CAD-TVD (LAD, LCX, RCA), PRIMARY PTCA+DES TO RCA WITH 3.5 X 40 MM METAFOR DONE ON 04/05/2022, (CABG LATER). Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. CILODOC 50MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 4) TAB. TONACT 40MG ONCE DAILY AT 2PM TO CONTINUE.
- 5) TAB. NIKORAN 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 6) TAB. DYTOR 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 7) TAB. MUCINAC 600 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 8) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001229014

**Name**

Mr. B ANIL

**Patient Identifier**

ARHIP55630

**Age**

22Yr  
1Mth  
19Days

**Sex**

Male

**Date of Admission**

07-May-2022

**Date of Discharge  
MLC No**

**Address**

KOHEDA,Karimnagar,Telangana

**Ward/  
Bed No**

First  
Floor,  
Day  
Care,  
Bed  
no:DC  
1

**Primary Consultant**

Dr. Iftekarali (MS (Orthopaedics

K-WIRE REMOVAL 3RD AND 4TH TOE RIGHT

SURGERY : K-WIRE REMOVAL 3RD AND 4TH TOE RIGHT DONE ON 07/05/2022

Patient came for K-wire removal

PHYSICAL EXAMINATION:

ON ADMISSION

-----

afebrile  
PR-98/min  
BP-120/80mmhg  
RR-20/min  
RS-BAE+  
CVS-S1S2+  
P/A-Soft  
SPO2-98%

A 22 years old male patient Mr. ANIL came for k-wire removal . All necessary investigations were done and diagnosed as K-WIRE REMOVAL 3RD AND 4TH TOE RIGHT, SURGERY : K-WIRE REMOVAL 3RD AND 4TH TOE RIGHT DONE ON 07/05/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence she is being discharged with required medication and advice.



DISCHARGE MEDICATION:

- 
1. TAB. CEFTUM 500MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
  2. TAB. HIFENAC-P TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS.
  3. TAB. PAN 40 MG ONCE DAILY AT 8AM FOR 10 DAYS.
  4. TAB. AFFICAL PLUS ONCE DAILY AT 2 PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO DR. IFTEKARALI SIR OPD.

55629 RADHAVVA 70

K-WIRE REMOVAL RIGHT AND LEFT WRIST

SURGERY : K-WIRE REMOVAL RIGHT AND LEFT WRIST DONE ON 07/05/2022

Patient came for K-wire removal

#### PHYSICAL EXAMINATION:

##### ON ADMISSION

-----  
afebrile  
PR-99/min  
BP-120/80mmhg  
RR-20/min  
RS-BAE+  
CVS-S1S2+  
P/A-Soft  
SPO2-98%

A 70 years old female patient RADHAVVA came for k-wire removal . All necessary investigations were done and diagnosed as K-WIRE REMOVAL RIGHT AND LEFT WRIST, SURGERY : K-WIRE REMOVAL RIGHT AND LEFT WRIST DONE ON 07/05/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence she is being discharged with required medication and advice.

#### DISCHARGE MEDICATION:

- 
1. TAB. CEFTUM 500MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
  2. TAB. HIFENAC-P TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS.
  3. TAB. PAN 40 MG ONCE DAILY AT 8AM FOR 10 DAYS.
  4. TAB. AFFICAL PLUS ONCE DAILY AT 2 PM FOR 10 DAYS.

REVIEW AFTER 7 DAYS TO DR. IFTEKARALI SIR OPD.

ARH1.0001063071

**Name**

Mr.  
NARAYANA  
GARREPALLI

**Patient Identifier**

ARHIP55563

**Age**

55Yr  
8Mth  
29Day  
s

**Sex**

Male

**Date of Admission**

30-  
Apr-  
2022

**Date of Discharge**  
**MLC No**

**Address**

3-  
149/1,SUNDILLA,KAMANPUR,Karimnagar,And  
hra Pradesh

**Ward/Bed No**

First  
Floor,  
CT  
POST,  
Bed  
no:CT  
5

**Primary Consultant**

Dr SOMASHEKAR K(MS,

CORONARY ARTERY DISEASE + LMCA+TRIPLE VESSEL DISEASE + SEVERE LV DYSFUNCTION + DM+HTN+S/P IRS OF RCA+AWMI

SURGERY -CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG TO OM,PDA] DONE ON 05/05/2022.

C/o left sided chest pain, shortness of breath on exertion since 3 days

AT ADMISSION:

Pt c/c

Afebrile

PR: 88/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 55 years old male patient Mr. NARAYANA GARREPALLI came with c/o left sided chest pain, shortness of breath on exertion since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE + LMCA+TRIPLE VESSEL DISEASE + SEVERE LV DYSFUNCTION + DM+HTN+S/P IRS OF RCA+AWMI, SURGERY -CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG TO OM,PDA] DONE ON 05/05/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, PARADOXICAL SEPTAL MOTION, TRIVIAL MR, SEVERE LV SYSTOLIC DYSFUNCTION, GRADE-I DIASTOLIC DYSFUNCTION. NO PE/CLOT/VEG, EF-30%

BMI is 18.6 kg/m<sup>2</sup>.

Sr. Creatinine report on 03/02/2022 0.8 mg/dl.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. ND VIT ONCE DAILY AT 2PM TO CONTINUE.
- 4) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. ALPRAX 0.25 MG ONCE DAILY AT 9AM FOR 5 DAYS.
- 6) TAB. MET XL 25 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 7) TAB. CARDARONE 200 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 8) TAB. TRAMADOL 50 MG THRICE DAILY AT 8AM 2PM AND 8PM FOR 5 DAYS.
- 9) TAB. ROXSAFE CV 125+100 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.
- 10) TAB. DIXIN 0.25MG ONCE DAILY AT 8AM TO CONTINUE.
- 11) TAB. FAMOCID 40 MG ONCE DAILY AT 7AM BBF FOR 5 DAYS.
- 12) TAB. GEMER 1 MG ONCE DAILY AT 7AM BBF TO CONTINUE.

## REVIEW AFTER 11 DAYS TO CTVS OPD WITH FBS, PLBS REPORTS

ARH1.0001230601

		Mrs. ASHAMMA MOTHE	
<b>Patient Identifier</b>	ARHIP55604	<b>Age</b>	70Yr 0Mth 4Days
<b>Sex</b>	Female	<b>Date of Admission</b>	05-May-2022
<b>Date of Discharge MLC No</b>			
<b>Address</b>	3-47/2 REGUNTA,Karimnagar,Telangana	<b>Ward/ Bed No</b>	Second Floor, Female General Ward, Bed no:GW 4
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, IWM

MILD LV DYSFUNCTION, EF-35%

CORONARY ANGIOGRAM DONE ON 06/05/2022 - CAD-SVD (RCA)

PTCA+DES TO RCA (TWO STENTS) WITH 3.5 X 44 MM METAFOR TO RCA, 4.0 X 13 MM METAFOR TO RCA DONE ON 06/05/2022

C/o sudden onset of chest pain a/w SOB 3 days

AT ADMISSION:

Afebrile

PR: 82/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 70years old female patient Mrs. ASHAMMA MOTHE came with c/o sudden onset of chest pain a/w SOB 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, IWMI, MILD LV DYSFUNCTION, EF-35%, CORONARY ANGIOGRAM DONE ON 06/05/2022 - CAD-SVD (RCA), PTCA+DES TO RCA (TWO STENTS) WITH 3.5 X 44 MM METAFOR TO RCA, 4.0 X 13 MM METAFOR TO RCA [LOT NO: MH20 , S/N :CM44MH20036 & LOT NO: MH36 , S/N :CL13MH36020] DONE ON 06/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPITAB 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

.0001230496

<b>Name</b>	Mrs. PADMA BHUMADI		
<b>Patient Identifier</b>	ARHIP55577	<b>Age</b>	53Yr 0Mth 7Days
<b>Sex</b>	Female	<b>Date of Admission</b>	02- May- 2022
<b>Date of Discharge MLC No</b>		<b>Ward/ Bed No</b>	Second Floor, Female General Ward, Bed no:GW 3
<b>Address</b>	MALLANNAPET,Nirmal,Telangana		
<b>Primary Consultant</b>	Dr. SURESH GOUD		

RIGHT RENAL CALCULUS  
RIGHT PCNL+DJ STENTING DONE ON 05.05.2022

C/o Right loin pain, burning micturition since 10 days

#### AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

All required investigations done and enclosed



A 53 yrs old female patient Mrs. PADMA BHUMADI came to the hospital with c/o right loin pain, burning micturition since 10 days. All necessary investigations done and diagnosed as RIGHT RENAL CALCULUS, RIGHT PCNL+DJ STENTING DONE ON 05.05.2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice. Patient explained for stent removal after 3 weeks.

#### DISCHARGE MEDICATION:

-----

1. TAB: ROXSAFE CV 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: FAMOCID 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: NDQ10 ONCE DAILY AT 2PM FOR 10 DAYS
5. SYP: CREMAFFIN 15 ml ONCE DAILY AT 8PM

REVIEW AFTER 11 DAYS TO UROLOGY OPD, STENT REMOVAL AFTER 3 WEEKS

ARH1.0001229468

**Name**

Mr. S  
RAMAKRISHNA

**Patient Identifier**

ARHIP55609

**Age**

46Yr  
1Mth  
9Days

**Sex**

Male

**Date of Admission**

06-  
May-  
2022

**Date of Discharge**  
**MLC No**

**Address**

DURSHED,Karimnagar,Telangana

**Ward/Bed No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:105  
B

**Primary Consultant**

Dr. GOUTHAM ROY (

SCROTAL WALL WOUND SECONDARY TO S/P I & D  
SURGERY: SCROTAL WALL SECONDARY SUTURING DONE ON 07.05.2022

C/o non healing of left scrotal wound came for suturing

PHYSICAL EXAMINATION:

ON ADMISSION

-----

Pt c/c/c

afebrile

PR-80/min

BP-120/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 46yr old male patient Mr. RAMAKRISHNA came with c/o non healing of left scrotal wound came for suturing . All necessary investigations done and diagnosed as SCROTAL WALL WOUND SECONDARY TO S/P I & D, SURGERY: SCROTAL WALL SECONDARY SUTURING DONE ON 07.05.2022. Findings: Healing ulcer with granulation tissues. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ROXSAFE CV 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: CIPLOX 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: SOMPRAZ-L TWICE DAILY AT 8AM, 8PM FOR 10 DAYS.
4. TAB: ROTAVAUULT THRICE DAILY AT 8AM, 2PM AND 8PM FOR 7 DAYS.
5. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
6. TAB: ND Q10 ONCE DAILY AT 2PM FOR 10 DAYS.

Review after 7 days in General Surgery OPD.

ARH1.0001230704

**Name**

Mr. RENDLA  
KAMALAKAR

**Patient Identifier**

ARHIP55652

**Age**

34Yr  
0Mth  
1Days

**Sex**

Male

**Date of  
Admission**

09-  
May-  
2022

**Date of Discharge  
MLC No**

**Address**

THADAGONDA,Sircilla,Telangana

**Ward/Bed  
No**

First  
Floor,  
SICU,  
Bed  
no:SICU  
5

**Primary Consultant**

DR. NIKHIL GOLI --NEUROLOGY

MULTIPLE HAEMORRHAGIC CONTUSIONS  
ACUTE SAH  
SDH  
FRACTURE RIGHT LATERAL AND MEDIAL PTERYGOID PLATE  
ASPIRATION

Alleged history of slip and fall from 2 wheeler on 08/05/2022 at 2 p.m.  
Ear injury with bleed present

#### PHYSICAL EXAMINATION:

##### ON ADMISSION

-----

Patient connected to ventilator

PR-130/min

BP-80/50mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

P/A-Soft

SPO2-84%

GCS: E1,V1,M1

A 34 yrs old male patient Mr. RENDLA KAMALAKAR came with alleged history of slip and fall from 2 wheeler on 08/05/2022 at 2 p.m, Ear injury with bleed present. All necessary investigations done and diagnosed as MULTIPLE HAEMORRHAGIC CONTUSIONS, ACUTE SAH, SDH, FRACTURE RIGHT LATERAL AND MEDIAL PTERYGOID PLATE, ASPIRATION. Managed conservatively. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA.

ARH1.0001082508

<b>Name</b>		Mr. BAYYANI MALLAIAH	
<b>Patient Identifier</b>	ARHIP55538	<b>Age</b>	65Yr 11Mth 9Days
<b>Sex</b>	Male	<b>Date of Admission</b>	28-Apr-2022
<b>Date of Discharge MLC No</b>			
<b>Address</b>	MADHAPUR,Karimnagar,Telangana	<b>Ward/ Bed No</b>	First Floor, MICU, Bed no:MIC U 3
<b>Primary Consultant</b>	DR. NIKHIL GOLI --NEUROLOGY		

CVA-ACUTE INFARCT IN RIGHT MCA TERRITORY  
POST PTCA  
AKI

C/o Weakness of right upper limb and lower limb, slurring of speech since 1 day  
k/c/o HTN, T2DM, CAD  
S/P PTCA

AT ADMISSION:

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 65 years old male patient Mr. BAYYANI MALLAIAH came with c/o weakness of right upper limb and lower limb, slurring of speech since 1 day. k/c/o HTN, T2DM, CAD. All necessary investigations were done and diagnosed as CVA-ACUTE INFARCT IN RIGHT MCA TERRITORY, POST PTCA, AKI. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA.



ARH1.0001230652

		Mrs. BHARATHI GAJJELLI	
<b>Name</b>			
<b>Patient Identifier</b>	ARHIP55627	<b>Age</b>	62Yr 0Mth 2Days
<b>Sex</b>	Female	<b>Date of Admission</b>	07-May-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	3-8-22, SHANTHINAGAR,,Sircilla,Telangana	<b>Ward/ Bed No</b>	First Floor, MICU, Bed no:MICU 5
<b>Primary Consultant</b>	DR. SRI KARAN UDDESH --INTERNAL		

ACUTE HEART FAILURE  
COMMUNITY ACQUIRED PNEUMONIA  
DENOVO DIABETES MELLITUS  
CAD WITH SEVERE LV DYSFUNCTION

Patient presented with complaints of fever cough since 8 days, shortness of breath grade-IV since 1 day

**AT ADMISSION:**

Patient drowsy, gasping  
PR: 116/min  
BP: 180/100mmHg  
RS: BAE+, crepts+  
CVS: S1S2  
RR: 34/min  
SPO2: 70% on room air  
P/A: Soft

A 62-year-old female patient Mrs. BHARATHI GAJJELLI presented with the above-mentioned complaints. Patient was drowsy and immediately intubated and connected to mechanical ventilator. Cardiology consultation was taken and advice followed. Patient was hypotensive and treated with INJ. NORADRENALINE, INJ. LASIX, INJ HUMAN ACTRAPID INSULIN AND WITH ANTIBIOTICS, ANTI-PLATELETS AND STATINS. On day 2 patient got extubated and required 4 L of O2 support . Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA.



55656

ARH1.0001229999

<b>Name</b>	Mrs. VAJRA KOPPULA
<b>Patient Identifier</b>	ARHIP55656
<b>Sex</b>	Female
<b>Date of Discharge</b>	
<b>MLC No</b>	
<b>Address</b>	vemulawada,Sircilla,Telangana
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY
<b>Age</b>	53Yr 0Mth 21Days
<b>Date of Admission</b>	09-May-2022
<b>Ward/ Bed No</b>	Ground Floor, Emergency Ward, Bed no:EME2

PREOPERATIVE CARDIAC EVALUATION WITH ECG CHANGES  
NORMAL LV SYSTOLIC FUNCTION  
R/F: HYPERTENSION, DIABETES MELLITUS  
CORONARY ANGIOGRAM (09/05/2022) - PROXIMAL LAD MILD DISEASE  
ANOMALOUS RCA ORIGIN FOR LEFT SINUS  
ADV: MEDICAL MANAGEMENT

Patient came for preoperative cardiac evaluation with ECG changes

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 53 years old female patient Mrs. VAJRA KOPPULA patient came for preoperative cardiac evaluation with ECG changes. All necessary investigations were done and diagnosed as PREOPERATIVE CARDIAC EVALUATION WITH ECG CHANGES, NORMAL LV SYSTOLIC FUNCTION, R/F: HYPERTENSION, DIABETES MELLITUS CORONARY ANGIOGRAM (09/05/2022) - PROXIMAL LAD MILD DISEASE ANOMALOUS RCA ORIGIN FOR LEFT SINUS, ADV: MEDICAL MANAGEMENT. Patient can undergo non-cardiac surgery under mild risk. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. TAZLOC 80 MG ONCE DAILY AT 8AM TO CONTINUE.
2. TAB. AZITOR 20 MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. OXRAMET XR 10 /500 ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER SURGERY TO CARDIAC OPD

ARH1.0001230528

**Name**

Mr. MALLAIAH  
BOLLAM

**Patient  
Identifier**

ARHIP55588

**Age**

66Yr  
0Mth  
5Days

**Sex**

Male

**Date of  
Admission**

04-May-  
2022

**Date of  
Discharge  
MLC No**

**Address**

ANANTHARAM,Sircilla,Telangana

**Ward/  
Bed No**

Second  
Floor,  
Male  
General  
Ward,  
Bed  
no:MG  
W 24

**Primary  
Consultant**

Dr. Vidya Sagar A--

CORONARY ARTERY DISEASE, UNSTABLE ANGINA

MILD LV DYSFUNCTION [EF-45%]

R/F : T2DM

CORONARY ANGIOGRAM DONE ON 06/05/2022 - CAD-SVD (RCA)

PTCA+DES TO RCA WITH 3.0 X 19 MM METAFOR TO PROXIMAL RCA, 3.0 X 24 MM 3V  
ASTRA TO MID RCA DONE ON 06/05/2022

C/o chest pain a/w sweating since 1 day

AT ADMISSION:

Afebrile

PR: 81/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 66years old male patient Mr. MALLAIAH came with c/o chest pain a/w sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, MILD LV DYSFUNCTION [EF-45%], R/F : T2DM , CORONARY ANGIOGRAM DONE ON 06/05/2022 – CAD-SVD (RCA), PTCA+DES TO RCA WITH 3.0 X 19 MM METAFOR TO PROXIMAL RCA, 3.0 X 24 MM 3V ASTRA TO MID RCA DONE ON 06/05/2022 . Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. CILODOC 50 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 5) TAB. GLYCOMET GP 1 MG ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001230481

**Name**

Mrs. YELLAMMA  
PARUNANDI

**Patient  
Identifier**

ARHIP55571

**Age**

75Yr  
0Mth  
7Days

**Sex**

Female

**Date of  
Admission**

02-  
May-  
2022

**Date of  
Discharge  
MLC No**

**Address**

KOTHAPALLY,Karimnagar,Telangana

**Ward/  
Bed No**

Second  
Floor,  
Female  
General  
I Ward,  
Bed  
no:GW  
11

**Primary  
Consultant**

Dr. RAMCHANDER TORREM

CKD STAGE-V

DM AND HTN

C/o swelling of feet, decreased appetite

AT ADMISSION:

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 75 years old female patient Mrs. YELLAMMA PARUNANDI came with c/o swelling of feet, decreased appetite. All necessary investigations were done and diagnosed as CKD STAGE-V, DM AND HTN. 2 PCV transfusions given, 2 sessions of haemodialysis done . Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB. CEFARAX-CV TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
2. TAB. DYTOR 10 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. METOZ 10 MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. KETO CHECK TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
5. TAB. CINOD 10 MG ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. GEROZ-LP THRICE DAILY AT 8AM 2PM 8PM FOR 10 DAYS.
7. TAB. SOBINIX DS TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
8. TAB. MULTI-8 ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 11 DAYS IN NEPHROLOGY OPD

ARH1.0001230611		<b>Name</b>	Mrs. J VIJAYA LAXMI
<b>Patient Identifier</b>	ARHIP55608	<b>Age</b>	68Yr 0Mth 3Days
<b>Sex</b>	Female	<b>Date of Admission</b>	06- May- 2022
<b>Date of Discharge MLC No</b>			
<b>Address</b>	MUKARAMPURA,Karimnagar,Telangana	<b>Ward/ Bed No</b>	Second Floor, Female Genera l Ward, Bed no:GW 1
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, NSTEMI

NORMAL LV SYSTOLIC FUNCTION [EF-60%]

CORONARY ANGIOGRAM DONE ON 06/05/2022 - CAD-DVD (LAD, RCA)

PTCA+DES TO LAD, RCA (TWO STENTS) WITH 2.75 X 18 MM PRANOVA TO LAD, 3.5 X 28 MM 3V ASTRA TO RCA DONE ON 06/05/2022

C/o chest pain a/w palpitations since 1 day

AT ADMISSION:

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft



A 68 years old female patient Mrs. J VIJAYA LAXMI came with c/o chest pain a/w palpitations since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, NORMAL LV SYSTOLIC FUNCTION [EF-60%], CORONARY ANGIOGRAM DONE ON 06/05/2022 – CAD-DVD (LAD, RCA), PTCA+DES TO LAD, RCA (TWO STENTS) WITH 2.75 X 18 MM PRANOVA TO LAD, 3.5 X 28 MM 3V ASTRA TO RCA DONE ON 06/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. CILODOC 50 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 4) TAB. TAZLOC 40MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001226633

<b>Name</b>	Mr. SHANKARAIAH KOTHAPALLY
<b>Patient Identifier</b>	ARHIP55576
<b>Age</b>	49Yr 3Mth 23Days
<b>Sex</b>	Male
<b>Date of Admission</b>	02-May-2022
<b>Date of Discharge</b>	
<b>MLC No</b>	
<b>Address</b>	H.NO: 2-72, VENKATARAOPET, LUXKETIPET, MANCHIRAIL, Other, Telangana
<b>Ward/Bed No</b>	Second Floor, Male General Ward, Bed no: GW 14
<b>Primary Consultant</b>	DR. SUBRAT KUMAR SOREN --NEUROSURGERY

RIGHT SIDE CALVARIAL DEFECT  
SURGERY: RIGHT AUTOLOGOUS CRANIOPLASTY DONE ON 05/03/2022

Patient came for autologous cranioplasty

K/c/o CVA, IC Bleed and HTN

AT ADMISSION:

Patient c/c/c  
PR: 88/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 49 years old male patient Mr. SHANKARAIAH KOTHAPALLY came for autologous cranioplasty, K/c/o CVA, IC Bleed and HTN. All necessary investigations were done and diagnosed as RIGHT SIDE CALVARIAL DEFECT, SURGERY: RIGHT AUTOLOGOUS CRANIOPLASTY DONE ON 05/03/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. LEVIPIL 500 MG TWICE DAILY AT 8AM AND 8PM FOR 11 DAYS
2. TAB. TELMA 40 MG ONCE DAILY AT 8AM FOR 11 DAYS
3. TAB. PAN 40MG ONCE DAILY AT 7AM (BBF) FOR 7 DAYS.
4. TAB. AUGMENTIN DUO TWICE DAILY AT 8AM AND 8PM FOR 11 DAYS
5. TAB. DOLO 650 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.

REVIEW AFTER 11 DAYS IN NEUROSURGERY OPD

ARH1.0001230507

<b>Name</b>		Mr. R PARVATHI	
<b>Patient Identifier</b>	ARHIP55575	<b>Age</b>	70Yr 0Mth 7Days
<b>Sex</b>	Male	<b>Date of Admission</b>	02-May-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	karimnagar,Karimnagar,Telangana		Second Floor, Semi Private, Bed no:111B
<b>Primary Consultant</b>	DR. NIKHIL GOLI --NEUROLOGY		

## LEFT DORSAL MEDULLARY CEREBELLAR INFARCT

C/o Giddiness, headache, nausea and vomiting since 2 days

### AT ADMISSION:

PR: 92/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 70 years old female patient R PARVATHI came with c/o giddiness, headache, nausea and vomiting since 2 days. All necessary investigations were done and diagnosed as LEFT DORSAL MEDULLARY CEREBELLAR INFARCT . Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE
- 2) TAB. STORVAS 40 MG ONCE DAILY AT 2PM TO CONTINUE
- 3) TAB. ZORYL-M1 **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE
- 4) TAB. DAPARYL 10 MG ONCE DAILY AT 2PM TO CONTINUE
- 5) TAB. SARTEL-H ONCE DAILY AT 2PM TO CONTINUE
- 6) TAB. ZEVERT 20 MG **TWICE IN A DAY AT 8 AM 8 PM**
- 7) TAB. NEUROCETAM ONCE DAILY AT 2PM TO CONTINUE
- 8) TAB. ZOFER 4 MG **THRICE IN A DAY AT 8 AM 2 PM 8 PM** TO CONTINUE
- 9) TAB. PANTOCID 40MG ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.

REVIEW AFTER 10 DAYS IN DR NIKHIL GOLI SIR OPD

ARH1.0001230475

**Name**

Mrs. VEERABATHINI  
THARA

**Patient  
Identifier**

ARHIP55654

**Age**

45Yr  
0Mth  
7Days

**Sex**

Female

**Date of  
Admission**

09-  
May-  
2022

**Date of  
Discharge  
MLC No**

**Address**

J.P NAGAR,Sircilla,Telangana

**Ward/  
Bed No**

First  
Floor,  
Day  
Care,  
Bed  
no:DC  
3

**Primary  
Consultant**

Dr SOMASHEKAR K(MS,MCH

AV MALFORMATION IN RIGHT WRIST  
AV MALFORMATION EXCISION IN RIGHT WRIST ANTERIORLY DONE ON 09/05/2022

Complaint of swelling and pain in right wrist since 15 days

AT ADMISSION:

Patient c/c/c  
PR: 82/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 45 years old female patient Mrs. VEERABATHINI THARA came with complaint of swelling and pain in right wrist since 15 days. All necessary investigations were done and diagnosed as AV MALFORMATION IN RIGHT WRIST, AV MALFORMATION EXCISION IN RIGHT WRIST ANTERIORLY DONE ON 09/05/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

- 1) TAB. ROXSAFE CV 500+125 MG THRICE DAILY AT 8AM 2PM, 8PM FOR 5 DAYS.
- 2) TAB. LINEZOLID 600 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS.
- 3) TAB. ULTRACET THRICE DAILY AT 8AM 2PM, 8PM FOR 5 DAYS.

REVIEW AFTER 5 DAYS TO CTVS OPD



ARH1.0001230519

<b>Name</b>	Mrs. JADAV BHIKKI BAI
<b>Patient Identifier</b>	ARHIP55583
<b>Sex</b>	Female
<b>Date of Discharge MLC No</b>	
<b>Address</b>	LINGAPUR,,Asifabad,Telangana
<b>Primary Consultant</b>	Dr Chandra Shekar Sathineni

<b>Age</b>	85Yr 0Mth 6Days
<b>Date of Admission</b>	03- May- 2022
<b>Ward/ Bed No</b>	Second Floor, Semi Private , Bed no:111 A

## UROSEPSIS WITH SEPTIC SHOCK

C/o pain abdomen since 10 days  
burning micturition since 1 week

Known case of hypertension on medication

### AT ADMISSION:

Afebrile

PR: 75/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 85 years old female patient Mrs. JADAV BHIKKI BAI came with c/o pain abdomen since 10 days, burning micturition since 1 week. Known case of hypertension on medication. All necessary investigations were done and diagnosed as UROSEPSIS WITH SEPTIC SHOCK. Managed conservatively. Urologist consultation taken and advice followed. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

- 1) TAB. TAXIM-O 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 2) TAB. PAN-D 40MG ONCE DAILY AT 7AM (BBF) FOR 7 DAYS.
- 3) TAB. HEADNEURON ONCE DAILY AT 2PM FOR 10 DAYS
- 4) TAB. CALPOL 500 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001230418

Name

Mr.  
SAMPATH  
KUMAR  
ARUKATI

Patient Identifier

ARHIP55593

Age

32Yr  
0Mth  
10Days

Sex

Male

Date of  
Admission

04-  
May-  
2022

Date of Discharge  
MLC No

Address

MANTHANI,Karimnagar,Telangana

Ward/  
Bed No

Second  
Floor,  
Semi  
Private  
, Bed  
no:108  
B

Primary Consultant

Dr. GOUTHAM ROY (MS)

ACUTE APPENDICITIS

SURGERY: LAPROSCOPIC APPENDICECTOMY DONE ON 05.05.2022

C/o pain abdomen since 2 days

PHYSICAL EXAMINATION:

ON ADMISSION

-----

Pt c/c/c

afebrile

PR-80/min

BP-120/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 32yr old male patient Mr. SAMPATH KUMAR ARUKAT came with c/o pain abdomen since 2 days . All necessary investigations done and diagnosed as ACUTE APPENDICITIS, SURGERY: LAPROSCOPIC APPENDICECTOMY DONE ON 05.05.2022. Findings: Inflamed appendix retrocaecal position and adherent to retroperitoneum, Inflamed IC junction and surrounding moiety. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 15 DAYS
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 5 DAYS.
4. TAB: PANTOCID-L **TWICE IN A DAY AT 8 AM 8 PM** 15 DAYS.
5. GLUTAVALT SACHETS ONCE DAILY AT 2PM FOR 15 DAYS.

Review after 7 days in General Surgery OPD.

ARH1.0001012134

**Name**

Mr. RAHEMUDDIN  
MD

**Patient  
Identifier**

ARHIP55564

**Age**

59Yr  
9Mth  
25Days

**Sex**

Male

**Date of  
Admission**

30-  
Apr-  
2022

**Date of  
Discharge  
MLC No**

**Address**

9-3-160, SRINAGAR  
COLONY,Karimnagar,Andhra Pradesh

**Ward/  
Bed No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:108  
A

**Primary  
Consultant**

DR. NIKHIL GOLI --NEUROLOGY

POSTERIOR CIRCULATION STROKE  
HYPERTENSION, TYPE II DIABETES MELLITUS

C/o weakness of left upper limb and lower limb, slurring of speech, giddiness and  
generalised weakness since 2 days

#### PHYSICAL EXAMINATION:

#### ON ADMISSION

-----

Pt c/c/c

afebrile

PR-80/min

BP-120/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 59yr old male patient Mr. RAHEMUDDIN MD came with c/o weakness of left upper limb and lower limb, slurring of speech, giddiness and generalised weakness since 2 days. All necessary investigations done and diagnosed as POSTERIOR CIRCULATION STROKE, HYPERTENSION, TYPE II DIABETES MELLITUS. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ECOSPRIN 150 MG ONCE DAILY AT 2 PM TO CONTINUE
2. TAB: ATORVAS 40 MG ONCE DAILY AT 8 PM TO CONTINUE
3. TAB: CLOPITAB 75 MG ONCE DAILY AT 2 PM TO CONTINUE

Review after 7 days in DR NIKHIL GOLI SIR OPD.

ARH1.0001230722

**Name**

Mrs. D  
SRILATHA

**Patient Identifier**

ARHIP55662

**Age**

44Yr 0Mth  
0Days

**Sex**

Female

**Date of  
Admission**

09-May-  
2022

**Date of Discharge  
MLC No**

**Address**

NTPC KRISHNA NAGAR  
GODAVARIKHANI, Karimnagar, Telangana

**Ward/  
Bed No**

Ground  
Floor,  
Emergency  
Ward, Bed  
no: EME5

**Primary Consultant**

Dr. GOUTHAM ROY (

EPIDERMOID CYST OF THE BACK

SURGERY: BACK EPIDERMOID CYST EXCISION DONE ON 09.05.2022

C/o swelling over the back, midline thoracic region

PHYSICAL EXAMINATION:

ON ADMISSION

-----

Pt c/c/c

afebrile

PR-80/min

BP-120/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 44yr old female patient Mrs. D SRILATHA came with c/o swelling over the back, midline thoracic region. All necessary investigations done and diagnosed as EPIDERMOID CYST OF THE BACK, SURGERY: BACK EPIDERMOID CYST EXCISION DONE ON 09.05.2022. Findings: small cyst measuring 1 x 1 cm noted in the back over the midline in the thoracic region. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. TAB: ROTAVAUULT THRICE DAILY **AT 8 AM 2PM 8 PM** 5 DAYS.
5. GLUTAVAUULT SACHETS ONCE DAILY AT 2PM FOR 15 DAYS.

Review after 7 days in General Surgery OPD.



ARH1.0001230530

**Name**

Mr. R VISHNU

**Patient Identifier**

ARHIP55637

**Sex**

Male

**Date of Discharge  
MLC No**

**Address**

SIRICILLA,Telangana

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

**Age**

36Yr 0Mth  
6Days

**Date of Admission**

07-May-2022

**Ward/ Bed No**

First Floor,  
CICU ,  
Bed no:CICU10

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR  
MODERATE LV DYSFUNCTION, EF-35%  
CORONARY ANGIOGRAM DONE ON 04/05/2022 - CAD-SVD (LAD)  
PTCA+DES TO LAD WITH 3.5 X 28 MM XIENCE XPEDITION DONE ON 04/05/2022  
R/F: DENOVO DIABETES

C/o chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 80/min

BP: 90/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft



A 36 years old male patient Mr. R. VISHNU came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR, MODERATE LV DYSFUNCTION, EF-35%, CORONARY ANGIOGRAM DONE ON 04/05/2022 - CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.5 X 28 MM XIENCE XPEDITION DONE ON 04/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. AXCER 90MG TWICE IN A DAY AT 8 AM 8 PM TO CONTINUE.
- 3) TAB. ROZAVEL 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. NEXPRO 20 MG ONCE DAILY AT 8AM TO CONTINUE.

LIFE STYLE MODIFICATIONS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001171665

**Name**

Mr. MOHD AHMED

**Patient Identifier**

ARHIP55632

**Age**

59Yr  
2Mth  
26Days

**Sex**

Male

**Date of Admission**

07-May-2022

**Date of Discharge  
MLC No**

07-May-2022

**Address**

BENDA PALLY  
KORUTLA,Karimnagar,Telangana

**Ward/Bed No**

First Floor,  
Day Care,  
Bed no:DC 2

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

**Consultants**

**Surgeons**

Dr. Vidya Sagar A--CARDIOLOGY

**Anesthesiologists**

☐ **Diagnosis**

**Diagnosis**

Disease

Disease Type

CAD UNSTABLE ANGINA  
POST PCI-2019  
CORONARY ANGIOGRAM DONE ON 7/5/2022-SVD(PLV)  
RISK FACTOR:HYPERTENSION.DIABETES MELLITUS.

C/o chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 59 years old male patient Mr. MOHD AHMED came with c/o chest pain since 1 day.  
All necessary investigations were done and diagnosed as CAD UNSTABLE ANGINA, POST  
PCI-2019, CORONARY ANGIOGRAM DONE ON 7/5/2022-SVD(PLV), PLAN FOR PTCA+DES TO PLV.  
Patient is being discharged in hemodynamically stable condition with required  
medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. SARTEL 40MG ONCE DAILY AT 2PM TO CONTINUE.

2. TAB. ANGISPAN TR **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS
4. TAB. ROZAVEL 40MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. CLOPITAB-A 105+75MG ONCE DAILY AT 2PM TO CONTINUE.
6. TAB: GLIMCORD M3 FORTE ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001079469

**Name**

Mrs. HAMDABI MD

**Patient Identifier**

ARHIP55620

**Age**

61Yr  
0Mth  
24Days

**Sex**

Female

**Date of Admission**

06-May-2022

**Date of Discharge  
MLC No**

**Address**

1-18 KONDAPALLIKI,Karimnagar,Telangana

**Ward/  
Bed No**

Second  
Floor,  
Female  
General Ward,  
Bed no:GW  
7

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, NSTEMI, SR

SEVERE LV SYSTOLIC DYSFUNCTION

S/P OLD CAD PTCA STENT TO LAD (2015)

CORONARY ANGIOGRAM (09/05/2022) -CAD-SVD (Mild ISR-Proximal LAD)

PLAN MEDICAL MANAGEMENT

R/F : HTN, HYPOTHYROIDISM

C/o left sided chest pain associated with palpitations since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 61 years old female patient Mrs. HAMDABI MD came with c/o left sided chest pain associated with palpitations since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, SEVERE LV SYSTOLIC DYSFUNCTION, S/P OLD CAD PTCA STENT TO LAD (2015), CORONARY ANGIOGRAM (09/05/2022) -CAD-SVD (Mild ISR-Proximal LAD), PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB: CARDIVAS 6.25MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. THYRONORM 100MCG ONCE DAILY AT 7AM BBF TO CONTINUE.
6. TAB. DYTOR 5MG ONCE DAILY AT 2PM TO CONTINUE.
7. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD



ARH1.0001230338

**Name**

Mr.  
NIMMALA  
POCHAIHA

**Patient Identifier**

ARHIP55516

**Age**

62Yr  
3Mth  
13Days

**Sex**

Male

**Date of Admission**

27-Apr-2022

**Date of Discharge  
MLC No**

**Address**

5-6-218, MARUTHI  
NAGAR,Karimnagar,Telangan  
a

**Ward/  
Bed No**

First  
Floor,  
CT  
POST,  
Bed  
no:CT  
2

**Primary Consultant**

Dr SOMASHEKAR K(MS,MCH

CHRONIC RHEUMATIC HEART DISEASE + SEVERE MS+MR+SEVERE AS WITH  
AR+ATRIAL FLUTTER WITH FAST VENTRICULAR RATE

**SURGERY:** **DOUBLE VALVE REPLACEMENT** [AVR WITH SJ NO. 21 MM & MVR WITH  
SJ NO. 23MM MECHANICAL VALVES] DONE ON 04/05/2022.

C/o shortness of breath on exertion since 10 days

AT ADMISSION:

Pt c/c

Afebrile

PR: 88/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 62 years old male patient Mr. NIMMALA POCHAIHAH came with c/o shortness of breath on exertion since 10 days. All necessary investigations were done and diagnosed as CHRONIC RHEUMATIC HEART DISEASE + SEVERE MS+MR+SEVERE AS WITH AR+ATRIAL FLUTTER WITH FAST VENTRICULAR RATE, **SURGERY: DOUBLE VALVE REPLACEMENT** [AVR WITH SJ NO. 21 MM & MVR WITH SJ NO. 23MM MECHANICAL VALVES] DONE ON 04/05/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, she is being discharged with required medication and advice.

POST DVR 2D ECHO REPORTS SHOWED POST DVR STATUS , PROSTHETIC VALVE INSITU, NO VALVULAR/ PARAVALVULAR LEAK, NORMAL FUNCTIONING PROSTHETIC MITRAL VALVE, MODERATE TR/ PAH. NO CLOT/PE/VEG

BMI is 22.3 kg/m<sup>2</sup>.

Sr. Creatinine report on 05/05/2022 1.0 mg/dl.

DISCHARGE MEDICATION:

-----

- 1) TAB. ACITROM 2 MG & 1MG ALTERNATE DAY AT 7PM TO CONTINUE.
- 2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. FLECAINIDE 50MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 4) TAB. ND VIT ONCE DAILY AT 2PM TO CONTINUE.
- 5) TAB. DOLO 650 MG THRICE DAILY AT 8AM 2PM AND 8PM FOR 5 DAYS.
- 6) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.
- 7) TAB. ALPRAX 0.25 MG ONCE DAILY AT 8PM FOR 5 DAYS.
- 8) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD WITH PT/INR REPORTS

55625

LOWER RESPIRATORY TRACT INFECTION  
RENAL INSUFFICIENCY

C/o pain abdomen, cough, vomiting and shortness of breath since 5 days

Known case of hypertension, type II diabetic mellitus, chronic kidney disease, COPD

AT ADMISSION:

Afebrile

PR: 72/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 75 years old male patient NARAYANA came with c/o pain abdomen, cough, vomiting and shortness of breath since 5 days. All necessary investigations were done and diagnosed as LOWER RESPIRATORY TRACT INFECTION, RENAL INSUFFICIENCY. Managed conservatively. Patient attendants requested for discharge, hence patient is being discharge at request.

#### DISCHARGE MEDICATION:

- 1) TAB. FPM ACT 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 2) TAB. LINOZEM TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 3) TAB. PULMOCLEAR TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 4) TAB. BILAHENZE M ONCE DAILY AT 8PM FOR 7 DAYS
- 5) TAB. HEADNEURON ONCE DAILY AT 2PM FOR 7 DAYS

#### REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001230643		<b>Name</b>		Mr. RAMULU G
<b>Patient Identifier</b>	ARHIP55626	<b>Age</b>	50Yr 0Mth 3Days	
<b>Sex</b>	Male	<b>Date of Admission</b>	07-May-2022	
<b>Date of Discharge</b>	07-May-2022			
<b>MLC No</b>				
<b>Address</b>	KMR,Karimnagar,Telangana	<b>Ward/Bed No</b>	Second Floor, Female General Ward, Bed no:GW 5	
<b>Primary Consultant Surgeons</b>	DR. NIKHIL GOLI --NEUROLOGY	<b>Consultants Anesthesiologists</b>		
<b>Diagnosis</b>	<div> <div>Diagnosis</div> <div> <div> <div>Disease</div> <div>Disease Type</div> </div> <div> <div>.</div> <div></div> </div> </div> </div>			

CEREBRO VASCULAR ACCIDENT ACUTE INFRACT ON LEFT LARGE MCA INFRACT

C/o sudden slip and fall at home followed by unable to work and stand

AT ADMISSION:

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 50 years old male patient RAMULU came with c/o sudden slip and fall at home followed by unable to work and stand. All necessary investigations were done and diagnosed as CEREBRO VASCULAR ACCIDENT ACUTE INFRACT ON LEFT LARGE MCA INFRACT. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA.

ARH1.0001215895

Name Mrs. D  
RENUKA

Patient Identifier ARHIP55547

Age 30Yr 10Mth 8Days

Sex Female

Date of Admission 29-Apr-2022

Date of Discharge

MLC No

Address RAJEEV NAGAR RAJANNA  
SIRCILLA ,Sircilla,Telangana

Ward/Bed No First Floor, CT  
POST, Bed no:CT 1

Primary Consultant Dr SOMASHEKAR  
K(MS,MCH(CTVS),Consultant-Cardio Thoracic &  
Vascular Surgeon)--C T  
SURGERY

Consultants

Surgeons Dr SOMASHEKAR  
K(MS,MCH(CTVS),Consultant-Cardio Thoracic &  
Vascular Surgeon)--C T  
SURGERY

Anesthesiologists Dr. K.S.D.KRISHNA  
KIRAN--  
ANAESTHESIOLOGY

Diagnosis

Diagnosis

[Add  
Diagnosis](#)

ARHIP55547

ARH1.0001215895

Surgery / Procedures  
Done

Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
AORTIC VALVE REPLACEMENT	06			

CHRONIC RHEUMATIC HEART DISEASE WITH SEVERE AR

**SURGERY:** AORTIC VALVE REPLACEMENT WITH SJ NO 19 MM MECHANICAL VALVE DONE ON 06/05/2022

C/o SOB on exertion since 2 weeks

ON ADMISSION VITAL

-----

Patient conscious, coherent

Afebrile

PR-82/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+,

P/A-Soft,

SPO2-98%

A 30 years old female patient RENUKA presented to hospital with c/o SOB on exertion since 2 weeks. All necessary investigations were done and diagnosed as CRHD WITH SEVERE AR+AS, **SURGERY:** AORTIC VALVE REPLACEMENT WITH SJ NO 19 MM MECHANICAL VALVE DONE ON 06/05/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence she is being discharged with required medication and advice.

POST AVR 2D ECHO REPORTS SHOWED PROSTHETIC VALVE INSITU, MILD LV DYSFUNCTION, NO VALVULAR /PARAVALVULAR LEAK, EF-50%.

BMI is 20.3 kg/m2



Sr. Creatinine report on 07/05/2022 1.0 mg/dl

DISCHARGE MEDICATION:

-----

- 1) TAB. ACITROM 1MG ONCE DAILY AT 7PM TO CONTINUE LIFE LONG.
- 2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. MET-XL 25MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 4) TAB. ND-VIT ONCE DAILY AT 2PM TO CONTINUE.
- 5) TAB. ALPRAX 0.25MG ONCE DAILY AT 9PM (HS) FOR 5 DAYS.
- 6) TAB. DOXY 100 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.
- 7) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.
- 8) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.
- 9) TAB. DOLO 650 MG THRICE DAILY AT 8AM 2PM AND 8PM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD WITH PT/INR REPORTS

Saleem

ARH1.0001230697

<b>Name</b>	Mr. MOHAMMAD SALEEM
<b>Patient Identifier</b>	ARHIP55646
<b>Sex</b>	Male
<b>Date of Discharge</b>	
<b>MLC No</b>	
<b>Address</b>	Jagital, Karimnagar, Telangana
<b>Primary Consultant</b>	Dr Chandra Shekar Sathineni

<b>Age</b>	45Yr 0Mth 3Days
<b>Date of Admission</b>	08-May-2022

<b>Ward/ Bed No</b>	First Floor, MICU, Bed no: MICU 2
---------------------	-----------------------------------

MULTIORGAN DYSFUNCTION SYNDROME  
HYPERTENSION  
DIABETES MELLITUS  
PERIPHERAL ARTERIAL DISEASE  
RIGHT DIABETIC FOOT  
LOWER RESPIRATORY TRACT INFECTION  
RENAL INSUFFICIENCY

C/o shortness of breath associated with pedal oedema since 1 day  
Alleged history of trauma sustained injury to right lower limb

AT ADMISSION:

Afebrile

PR: 124/min

BP: 180/100mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 45 years old male patient MOHAMMAD SALEEM came with c/o shortness of breath associated with pedal oedema since 1 day, alleged history of trauma sustained injury to right lower limb. All necessary investigations were done and diagnosed as MULTIORGAN DYSFUNCTION SYNDROME, HYPERTENSION, DIABETES MELLITUS, PERIPHERAL ARTERIAL DISEASE, RIGHT DIABETIC FOOT, LOWER RESPIRATORY TRACT INFECTION, RENAL INSUFFICIENCY . Managed conservatively. General Surgeon consultation taken in view of right diabetic foot and advised followed. Patient attendants requested for discharge, hence patient is being discharge at request.

DISCHARGE MEDICATION:

-----

- 1) TAB. FEROALFA -CV TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 2) TAB. LINOZEM 600 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 3) TAB. DOPAGYL 10 MG ONCE DAILY AT 2PM FOR 10 DAYS.
- 4) TAB. PULMOCLEAR TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 5) TAB. BILAHENZ ONCE DAILY AT 2PM FOR 10 DAYS.
- 6) TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM FOR 10 DAYS.
- 7) TAB. RENOSAVE ONCE DAILY AT 2PM FOR 10 DAYS.
- 8) TAB. PLETOZ 100 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 10 DAYS.
- 9) TAB. NICARDIA 20 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 10 DAYS.
- 10) CAP. VSL# 3 ONCE DAILY AT 2PM FOR 10 DAYS.

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001230767

		<b>Name</b>	Mrs. ZAREENA BEGUM	
<b>Patient Identifier</b>	ARHIP55682	<b>Age</b>	59Yr 0Mth 1Days	
<b>Sex</b>	Female	<b>Date of Admission</b>	10-May- 2022	
<b>Date of Discharge</b>				
<b>MLC No</b>				
<b>Address</b>	bellampalli,Mancherial,Telangana		<b>Ward/ Bed No</b>	Ground Floor, Emergenc y Ward, Bed no:EME7
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, ACUTE IWMI, TLT WITH TNK (07/05/2022)

MILD MR, SR

MILD LV SYSTOLIC DYSFUNCTION [EF-50%]

R/F : T2DM, HTN

CORONARY ANGIOGRAM (10/05/2022) -CAD-SVD (Recanalized RCA)

ADV: MEDICAL MANAGEMENT

C/o chest pain, SOB on exertion since 2 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 56/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 59 years old female patient Mrs. ZAREENA BEGUM came with c/o retrosternal chest pain, radiating to back since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, TLT WITH TNK (07/05/2022), MILD MR, SR, MILD LV SYSTOLIC DYSFUNCTION [EF-50%], R/F : T2DM, HTN, CORONARY ANGIOGRAM (10/05/2022) -CAD-SVD (Recanalized RCA), ADV: MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. TONACT 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. GLYCOMET 500MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. GLYCOMET SR P2 850 MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. AMLOKIND 80 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001230739

	Name		Mr. RAMAGIRI SATHAIAH	
Patient Identifier	ARHIP55673	Age	68Yr 0Mth 2Days	
Sex	Male	Date of Admission	09-May-2022	
Date of Discharge MLC No				
Address	Jagital Jaina,Karimnagar,Telangana		Ward/Bed No	First Floor, CICU , Bed no:CICU 9
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

DCMP, LBBB, MODERATE MR, SR,  
SEVERE LV SYSTOLIC DYSFUNCTION [EF-30%]  
R/F DENOVO T2DM, HTN, ALCOHOL, Br. ASTHMA

C/o severe SOB grade-IV, burning sensation in chest

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 98/min

BP: 140/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 68 years old male patient Mr. RAMAGIRI SATHAIAH came with c/o severe SOB grade-IV, burning sensation in chest. All necessary investigations were done and diagnosed as DCMP, LBBB, MODERATE MR, SR, SEVERE LV SYSTOLIC DYSFUNCTION [EF-30%], R/F DENOVO T2DM, HTN, ALCOHOL, Br. ASTHMA. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CARDIVAS 6.25MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. ALDACTONE 25MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. CIDMUS 50MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. SEROFLOW 250 MG 1 PUFF TWICE DAILY AT 8AM, 8PM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001229475

**Name**

Mrs. M LAXMI

**Patient Identifier**

ARHIP55690

**Age**

57Yr  
1Mth  
11Days

**Sex**

Female

**Date of Admission**

11-May-2022

**Date of Discharge  
MLC No**

**Address**

SATHRAJPALLY, VEMULAWADA, Telangana

**Ward/  
Bed No**

First  
Floor,  
Day  
Care,  
Bed  
no:DC  
2

**Primary Consultant**

Dr. Iftekarali (MS (Orthopaedics

POST-OPERATIVE CASE OF SUPRACONDYLAR FRACTURE RIGHT HUMERUS TO K-WIRE REMOVAL

SURGERY : K-WIRE REMOVAL DONE ON 11/05/2022

Patient came for K-wire removal

PHYSICAL EXAMINATION:

ON ADMISSION

-----  
afebrile  
PR-98/min  
BP-120/80mmhg  
RR-20/min  
RS-BAE+  
CVS-S1S2+  
P/A-Soft  
SPO2-98%

A 57 years old female patient Mrs. M LAXMI came for k-wire removal . All necessary investigations were done and diagnosed as POST-OPERATIVE CASE OF SUPRACONDYLAR FRACTURE RIGHT HUMERUS TO K-WIRE REMOVAL, SURGERY : K-WIRE REMOVAL DONE ON 11/05/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence she is being discharged with required medication and advice.



DISCHARGE MEDICATION:

- 
1. TAB. CEFTUM 500MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
  2. TAB. HIFENAC-P TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
  3. TAB. PAN 40 MG ONCE DAILY AT 8AM FOR 10 DAYS.
  4. TAB. DISENCHER **TWICE IN A DAY AT 8 AM 8 PM** FOR 10 DAYS.
  5. TAB. CALCIMAX **ONCE IN A DAY AT 2 PM** FOR 10 DAYS.

REVIEW AFTER 7 DAYS TO DR. IFTEKARALI SIR OPD.



Avr somasekar  
Venkatreddy tkr vr  
Cemented bipolar iftek  
Mastectomy goutham roy  
Pcni  
Pcni  
ursi

ARH1.0001230602

**Name**

Mrs. NOOKALA  
MALLU

**Patient  
Identifier**

ARHIP55623

**Age**

65Yr  
0Mth  
5Days  
07-  
May-  
2022

**Sex**

Female

**Date of  
Admission**

**Expired Date  
MLC No**

10-May-2022

**Address**

chennur,Mancheria,Telangana

**Ward/Bed No**

First  
Floor,  
CT  
POST,  
Bed  
no:CT  
6

**Primary  
Consultant**

Dr SOMASHEKAR  
K(MS,MCH(CTVS),Consultant-Cardio  
Thoracic & Vascular Surgeon)--C T  
SURGERY

**Consultants**

**Surgeons**

**Anesthesiologi  
sts**

Diagnosis  
S

**Diagnosis**

Disease	Disease Type
CORONARY ARTERY DISEASE .TRIPPLE VESSELE DISEASE .SEVERE LV DISFUNCTION .CADIOGENIC SHOCK. NSTEMI. VENTRICULAR ARRTHYMIA.	

C/o chest pain since 3 days

AT ADMISSION:

PR: 72/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 65 years old female patient Mrs. NOOKALA MALLU came with c/o chest pain since 3

days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE .TRIPPLE VESSELE DISEASE .SEVERE LV DISFUNCTION .CADIOGENIC SHOCK. NSTEMI. VENTRICULAR ARRTHYMIA. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and ionotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 01.15 AM on 10/05/2022.

#### CAUSE OF DEATH

-----

SUDDEN CARDIOPULMONARY ARREST SECONDARY TO SEVERE LV DYSFUNCTION, CAD-TVD

ARH1.0001171665

Name

Mr. MOHD AHMED

Patient Identifier

ARHIP55661

Age

59Yr 2Mth 28Days

Sex

Male

Date of Admission

09-May-2022

Date of Discharge  
MLC No

Address

BENDA PALLY  
KORUTLA,Karimnagar,Telangana

Ward/  
Bed No

First Floor,  
CICU ,  
Bed no:CICU11

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, NON STEMI, SR  
NORMAL LV FUNCTION, EF-60%  
S/P PTCA 2019  
CORONARY ANGIOGRAM DONE ON 7/5/2022-CAD-SVD(PLV)  
PLAN : PTCA+DES TO PLV

C/o chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 59 years old male patient Mr. MOHD AHMED came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NON STEMI, SR, NORMAL LV FUNCTION, EF-60%, S/P PTCA 2019, CORONARY ANGIOGRAM DONE ON 7/5/2022-CAD-SVD(PLV), PLAN : PTCA+DES TO PLV. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.

4. TAB. PREVAMET-AM 50MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. GLIMICARD M3 FORTE ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001230710

		<b>Name</b>	Mrs. AMAD BHEE MAHAMMAD	
<b>Patient Identifier</b>	ARHIP55671	<b>Age</b>	56Yr 0Mth 3Days	
<b>Sex</b>	Female	<b>Date of Admission</b>	09- May- 2022	
<b>Date of Discharge</b>				
<b>MLC No</b>				
<b>Address</b>	ASIFNAGAR,Karimnagar,Telangana		<b>Ward/ Bed No</b>	First Floor, HDU, Bed no:HD U 4
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY			

## ISCHAEMIC CARDIOMYOPATHY

SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%

CORONARY ANGIOGRAM DONE ON 12/05/2022 - CAD-DVD (LAD,RCA)

PLAN CABG.

R/F CKD, T2DM, CKD, ANAEMIA, Br.ASTHMA, DYSLIPIKEMIA

C/o chest pain, SOB on exertion since 1 day

At Admission

Afebrile

PR: 70/min

BP: 130/70 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-95%

A 56 years old female patient Mrs. AMAD BHEE MAHAMMAD came with c/o chest pain, SOB on exertion since 1 day. All necessary investigations were done and diagnosed as ISCHAEMIC CARDIOMYOPATHY, SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%, CORONARY ANGIOGRAM DONE ON 12/05/2022 – CAD-DVD (LAD, RCA), PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

1. TAB. CLOPITAB-A 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. TONACT 40 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. CARDIVAS 6.25 MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. MONOTRATE 10 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. FRUSELOC ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. FORACORT 200 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. ZORYL-M1 ONCE DAILY AT 8AM TO CONTINUE.
8. TAB. VOGS 0.3 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS IN CARDIAC OPD



ARH1.0001111763

<b>Name</b>		Mr. VENU MADHAV SINGARI	
<b>Patient Identifier</b>	ARHIP55713	<b>Age</b>	49Yr 9Mth 16Days
<b>Sex</b>	Male	<b>Date of Admission</b>	13-May-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	9-9-185/1, LAXMI NILAYAM RAM NAGAR,Karimnagar,Telangana	<b>Ward/ Bed No</b>	First Floor, RECOVERY ROOM, Bed no:RR 3
<b>Primary Consultant</b>	Dr. GOUTHAM ROY (MS		

BALANITIS WITH PHIMOSIS + ACUTE FISSURE IN ANO  
SURGERY: CIRCUMCISSION+LATERAL ANAL SPHINCTEROTOMY+ANAL DILATATION DONE ON  
13/05/22

C/o perineal pain, swelling since 1-2 months

#### PHYSICAL EXAMINATION:

##### ON ADMISSION

-----

Pt c/c/c

afebrile

PR-71/min

BP-100/60mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

SPO2-100%

A 49 yrs old male patient Mr. VENU MADHAV SINGARI came with c/o perineal pain, swelling since 1-2 months. All necessary investigations done and diagnosed as BALANITIS WITH PHIMOSIS + ACUTE FISSURE IN ANO, SURGERY: CIRCUMCISION + LATERAL SPHINCTERECTOMY + ANAL DILATATION DONE ON 14/05/2022. Findings: Dorsal slit technique followed and frenular artery ligated and prepenal skin excised, Severe anal spasm noted. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. T-BACT OINTMENT FOR L/A
5. SITZ BATH TWICE DAILY
6. SYP. LACTIHEP 3 TSP ONCE IN A DAY AT 8 PM
7. XYLOCAINE JELLY EVERY 4<sup>th</sup> hrly

Review after 7 days in General Surgery OPD.

ARH1.0001230776

**Name**

Mrs.  
GOUSEIYA  
BEGAM

**Patient Identifier**

ARHIP55687

**Age**

45Yr  
0Mth  
3Days

**Sex**

Female

**Date of  
Admission**

11-  
May-  
2022

**Date of Discharge  
MLC No**

**Address**

0-0 Shatrajupalli, Karimnagar, Telangana

**Ward/  
Bed No**

Second  
Floor,  
Female  
General Ward,  
Bed  
no:GW  
6

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

R/F: T2DM

CORONARY ANGIOGRAM DONE ON 11/05/2022 - CAD-SVD (LAD)

PRIMARY PTCA+DES TO LAD WITH 3.5 X 16 MM 3V ASTRA DONE ON 11/05/2022

C/o chest pain a/w palpitations since 1 day

AT ADMISSION:

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 45 years old female patient Mrs. GOUSEIYA BEGAM came with c/o chest pain a/w palpitations since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWTMI, NO TLT, SR, R/F: T2DM, CORONARY ANGIOGRAM DONE ON 11/05/2022 – CAD-SVD (LAD), PRIMARY PTCA+DES TO LAD WITH 3.5 X 16 MM 3V ASTRA [LOT NO: 240335016042A, S/N :22035162121] DONE ON 11/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. CILODOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 4) TAB. ROZAVEL 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001230694

**Name**

Mrs.  
MUJEEB  
UNNISA

**Patient Identifier**

ARHIP55672

**Age**

61Yr  
0Mth  
7Days

**Sex**

Female

**Date of  
Admission**

09-May-  
2022

**Date of Discharge  
MLC No**

**Address**

jagityal,Karimnagar,Telangana

**Ward/  
Bed No**

First  
Floor,  
CICU ,  
Bed  
no:CICU  
3

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, NSTEMI, SR

MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%

CORONARY ANGIOGRAM DONE ON 11/05/2022 - CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.0 X 20 MM 3V ASTRA DONE ON 11/05/2022  
R/F: T2DM, HTN, HYPOTHYROIDISM

C/o chest pain since 2 days

AT ADMISSION:

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 61 years old female patient Mrs. MUJEEB UNNISA came with c/o chest pain since 2 days . All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%, CORONARY ANGIOGRAM DONE ON 11/05/2022 - CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.0 X 20 MM 3V ASTRA [LOT NO: 240330020048A, S/N :22034205034] DONE ON 11/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASITA 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ATORVA 40MG ONCE DAILY AT 2PM TO CONTINUE.
- 4) TAB. OLOMET-VG2 TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 5) TAB. THYRONORM 75MCG ONCE DAILY AT 7AM TO CONTINUE.
- 6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.



ARH1.0001230807

Name

Mr. AJITH  
DUDEKULA

Patient Identifier

ARHIP55694

Age

35Yr  
0Mth  
3Days

Sex

Male

Date of  
Admission

11-May-  
2022

Date of Discharge  
MLC No

Address

H.NO:3-  
17,DHARMARAM,MALLAPUR,JAGITIAL,Other,Telanga  
na

Ward/  
Bed No

First  
Floor,  
CICU ,  
Bed  
no:CICU  
9

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

S

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

NORMAL LV FUNCTION, EF-55%

CORONARY ANGIOGRAM DONE ON 11/05/2022 - CAD-SVD (RCA)

PTCA TO RCA DONE ON 11/05/2022

R/F: ALCOHOLIC

C/o chest pain since 3 days

AT ADMISSION:

Afebrile

PR: 88/min

BP: 100/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 35 years old male patient Mr. AJITH DUDEKULA came with c/o chest pain since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR, NORMAL LV FUNCTION, EF-55%, CORONARY ANGIOGRAM DONE ON 11/05/2022 - CAD-SVD (RCA), PTCA TO RCA DONE ON 11/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPITAB 75 MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ROSAVEL 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

#### REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001192105

<b>Name</b>		Mr. ILLANDULA RAMULU	
<b>Patient Identifier</b>	ARHIP55522	<b>Age</b>	63Yr 2Mth 16Days
<b>Sex</b>	Male	<b>Date of Admission</b>	27-Apr-2022
<b>Date of Discharge MLC No</b>			
<b>Address</b>	7-25,LAXMIPUR,Karimnagar,Telangana	<b>Ward/ Bed No</b>	First Floor, MICU, Bed no:MIC U 10
<b>Primary Consultant</b>	DR. NIKHIL GOLI --NEUROLOGY		

ACUTE RIGHT MCA INFARCT

AKI

AF WITH FVR

C/o slurring of speech, sudden in onset of left sided weakness

AT ADMISSION:

Afebrile

PR: 84/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 63 years old male patient Mr. ILLANDULA RAMULU came with c/o slurring of speech, sudden in onset of left sided weakness . All necessary investigations were done and diagnosed as ACUTE RIGHT MCA INFARCT, AKI, AF WITH FVR. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB: CLOPITAB 75 MG ONCE DAILY AT 8AM TO CONTINUE
2. TAB: SOBNEX ONCE DAILY AT 8AM TO CONTINUE
3. TAB: KETOCHECK TWICE DAILY AT 8AM 8PM TO CONTINUE
4. TAB: CUDCE TWICE DAILY AT 8AM 8PM TO CONTINUE
5. TAB: PROLOMET XL 50 MG TWICE DAILY AT 8AM 8PM TO CONTINUE
6. TAB: IXAROLA 15MG ONCE DAILY AT 8AM TO CONTINUE
7. TAB: ROSEDAY 10MG ONCE DAILY AT 8PM TO CONTINUE

REVIEW AFTER 11 DAYS IN DR. NIKHIL GOLI sir OPD.

ARH1.0001230848		<b>Name</b>	Mr. M SRINIVAS
<b>Patient Identifier</b>	ARHIP55712	<b>Age</b>	42Yr 0Mth 2Days
<b>Sex</b>	Male	<b>Date of Admission</b>	12-May-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	KORUTLA, JAGITYAL,Telangana	<b>Ward/Bed No</b>	First Floor, CICU , Bed no:CICU 2
<b>Primary Consultant</b>	Dr. Vidya Sagar A-- CARDIOLOGY		

S

CORONARY ARTERY DISEASE, NSTEMI, SR

MILD LV SYSTOLIC DYSFUNCTION, EF-45%

S/P POST PTCA TO LAD

CORONARY ANGIOGRAM DONE ON 14/05/2022 - CAD-PROXIMAL LAD MILD ISR WITH ANEURYSM AND THROMBUS

PLAN CABG WITH GRAFT TO LAD, D1

R/F: HTN, T2DM

C/o chest pain, radiating to the back since 2 days

At Admission

Afebrile

PR: 82/min

BP: 120/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-96%

A 42 years old male patient Mr. SRINIVAS came with c/o chest pain, radiating to the back since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-45%, S/P POST PTCA TO LAD , CORONARY ANGIOGRAM DONE ON 14/05/2022 - CAD- PROXIMAL LAD MILD ISR WITH ANEURYSM AND THROMBUS, PLAN CABG WITH GRAFT TO LAD, D1. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 75 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. TICASAVE 90 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. CARDIVAS 3.125 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. ZORYL M FORTE ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. SARTEL-C 40 MG ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. PANTOCID 40MG ONCE DAILY AT 7AM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

55689 parveen 42

ARH1.0001230136      **Name**      Mr. SYED ASADULLA HUSSAIN

**Patient Identifier**      ARHIP55648      **Age**      62Yr 0Mth 21Days

**Sex**      Male      **Date of Admission**      08-May-2022

**Expired Date**      12-May-2022

**MLC No**

**Address**      hussenipura,Karimnagar,Telangana      **Ward/Bed No**      First Floor, CICU , Bed no:CICU 2

**Primary Consultant**      Dr. Vidya Sagar A-- CARDIOLOGY      **Consultants**

**Surgeons**      **Anesthesiologists**

☐ Diagnoses

**Diagnosis**

Disease	Disease Type
ACUTE LEFT VENTRICULAR FAILURE SEVERE LV SYSTOLIC DYSFUNCTION S/P: POST PTCA TO RCA R/F:DIABETES MELLITUS.	

C/o SOB since 7 days, b/l pedal edema

AT ADMISSION:

PR: 81/min

BP: 130/80mmHg

RS: BAE+



CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 62 years old male patient Mr. SYED ASADULLA HUSSAIN came with c/o SOB since 7 days, b/l pedal edema. All necessary investigations were done and diagnosed as ACUTE LEFT VENTRICULAR FAILURE SEVERE LV SYSTOLIC DYSFUNCTION, S/P: POST PTCA TO RCA, R/F:DIABETES MELLITUS CONGESTIVE CARDIAC FAILURE,SEVERE LV DYSFUNCTION,MODERATE MR,SEVERE TR&HOLLOW VISCUS PERFORATION. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and ionotropic support was given. CPR started immediately, continued for 40 minutes, according to ACLs guidelines. Patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 10.19 AM on 12/05/2022.

#### CAUSE OF DEATH

-----

CARDIOPULMONARY ARREST SECONDARY TO SEVERE HYPOTENSION, BRADY CARDIA, SEVERE LVF, S/P PTCA

ARH1.0001225314

**Name** Mr. MUJEEB KHAN

**Patient Identifier** ARHIP55635

**Age** 42Yr 5Mth 5Days

**Sex** Male

**Date of Admission** 07-May-2022

**Date of Discharge**

**MLC No**

**Address** PEDDAPALLY,Karimnagar,Telanga

**Ward/Bed No** First Floor, CT

	na	POST, Bed no:CT 3
<b>Primary Consultant</b>	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant- Cardio Thoracic & Vascular Surgeon)--C T SURGERY	<b>Consultants</b>
<b>Surgeons</b>	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant- Cardio Thoracic & Vascular Surgeon)--C T SURGERY	<b>Anesthesiologists</b> Dr. K.S.D.KRISHNA KIRAN-- ANAESTHESIOLOGY

Diagnosis

S

Diagnosis

[Add  
Diagnosis](#)

ARHIP55635	ARH1.000122531
------------	----------------

Surgery / Procedures

Done

Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
Femoro papliteal art Bypass Grafting				

PAD WITH ATHEROSCLEROTIC BLOCK IN RIGHT POPLTEAL ARTERY

SURGERY – FEMORO PAPLITEAL ART BYPASS GRAFTING USING 6 MM PTFE GRAFT DONE ON 11/05/2022.

C/o pain in b/l lower limbs

K/c/o HTN, CRHD with MS+AF

ON ADMISSION VITAL

-----

Patient conscious, coherent

Afebrile

PR-80/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 42 years old male patient Mr. MUJEEB KHAN presented to hospital with c/o pain in b/l lower limbs. All necessary investigations were done and diagnosed as PAD WITH ATHEROSCLEROTIC BLOCK IN RIGHT POPLTEAL ARTERY, SURGERY – FEMORO PAPLITEAL ART BYPASS GRAFTING USING 6 MM PTFE GRAFT DONE ON 11/05/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

-----

- 1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. DIXIN 0.25 MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. MET XL 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 4) TAB. ENCORATE CHRONO 200 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 5) TAB. ACITROM 2 MG ONCE IN A DAY AT 7PM TO CONTINUE.
- 6) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 7) TAB. LINEZOLID 600 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.
- 8) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.
- 9) TAB. TRAMADOL 50MG THRICE DAILY AT 8AM 2PM 8PM FOR 5 DAYS.
- 10) TAB. ALPRAX 0.25 MG ONCE DAILY AT 8PM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD

ARH1.0001230810

<b>Name</b>	
<b>Patient Identifier</b>	ARHIP55701
<b>Sex</b>	Female
<b>Date of Discharge</b>	
<b>MLC No</b>	
<b>Address</b>	2-191, KACHAPOOR,Telangana
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY

Mrs. RAJESHWARI  
PENTA

<b>Age</b>	64Yr 0Mth 5Days
<b>Date of Admission</b>	12-May-2022
<b>Ward/ Bed No</b>	First Floor, CICU , Bed no:CICU 3

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

MILD LV SYSTOLIC DYSFUNCTION, EF-40%

CORONARY ANGIOGRAM DONE ON 13/05/2022 - CAD-DVD (LAD, RAMUS)

PTCA+DES TO LAD WITH 3.0 X 29 MM METAFOR, RAMUS WITH 2.75 X 16 MM METAFOR  
DONE ON 13/05/2022

R/F: HTN

C/o SOB on exertion, chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 80/min

BP: 110/790mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 64 years old female patient Mrs. RAJESHWARI PENTA came with c/o SOB on exertion, chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWTMI, NO TLT, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-40%, CORONARY ANGIOGRAM DONE ON 13/05/2022 - CAD-DVD (LAD, RAMUS), PTCA+DES TO LAD WITH 3.0 X 29 MM METAFOR, RAMUS WITH 2.75 X 16 MM METAFOR [LOT NO: MH41, S/N :CM29MH41013], [LOT NO: MH21, S/N :CM16MH21020] DONE ON 13/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. CILODOC 50 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 4) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS.

#### REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001204954

Name

Mrs. B LAXMI

Patient Identifier

ARHIP55653

Age

76Yr  
2Mth  
27Days

Sex

Female

Date of Admission

09-May-2022

Expired Date  
MLC No

09-May-2022

Address

karimnagar,Karimnagar,Telangana

Ward/Bed No

First Floor,  
CICU ,  
Bed no:CICU 3

Primary Consultant  
Surgeons

Dr. Vidya Sagar A--CARDIOLOGY

Consultants  
Anesthesiologists

Diagnosis

Diagnosis

Disease	Disease Type
ISCHEMIC CARDIOMYOPATHY,SEVER MR AF,SEVER LVDYSFUNCTION.	

C/o chest pain a/w SOB since 1 days

AT ADMISSION:

PR: 131/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 76 years old female patient Mrs. B LAXMI came with c/o chest pain a/w SOB since 1 days. All necessary investigations were done and diagnosed as ISCHEMIC CARDIOMYOPATHY,SEVER MR AF,SEVER LVDYSFUNCTION. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and inotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLs guidelines. Patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 07.41 PM on 09/05/2022.

## CAUSE OF DEATH

-----

SUDDEN CARDIOPULMONARY ARREST SECONDARY TO ISCHEMIC  
CARDIOMYOPATHY,SEVER MR AF,SEVER LVDYSFUNCTION

ARH1.0001230626

**Name**

Mrs. A SUGUNA

**Patient Identifier**

ARHIP55612

**Age**

55Yr  
0Mth  
10Days

**Sex**

Female

**Date of  
Admission**

06-  
May-  
2022

**Date of Discharge  
MLC No**

06-May-2022

**Address**

karimnagar,Karimnagar,Telangana

**Ward/Bed No**

First  
Floor,  
Day  
Care,  
Bed  
no:DC  
1



**Primary Consultant  
Surgeons**

Dr. Vidya Sagar A--CARDIOLOGY  
Dr. Vidya Sagar A--CARDIOLOGY

**Consultants  
Anesthesiologists**

Diagnosis

Diagnosis

Disease	Disease Type
.	

CORONARY ARTERY DISEASE CHEST PAIN  
NORMAL LV FUNCTION EF-60%  
CORONARY ANGIOGRAM ON(6/5/2022)  
PLAN-MEDICAL MANAGEMENT

Patient came for pre-operative evaluation for ECG changes

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 55 years old female patient SUGUNA came for pre-operative evaluation for ECG changes. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE CHEST PAIN  
NORMAL LV FUNCTION EF-60%, CORONARY ANGIOGRAM ON(6/5/2022), PLAN-MEDICAL MANAGEMENT.

Patient advised to take TAB ECOSPRIN 150 MG daily after lunch [To be started after knee replacement]. Patient is being discharged in hemodynamically stable condition with required medication and advice.

ARH1.0001230708

**Name**

Mr. JUPAKA  
RAJESH

**Patient Identifier**

ARHIP55718

**Age**

35Yr 0Mth  
7Days

**Sex**

Male

**Date of  
Admission**

13-May-  
2022

**Date of Discharge  
MLC No**

13-May-2022

**Address**

MANDAMARRI,Telangana

**Ward/Bed No**

Ground  
Floor,  
Emergenc  
y Ward,  
Bed  
no:EME 8

**Primary Consultant  
Surgeons**

Dr. Vidya Sagar A--CARDIOLOGY  
Dr. Vidya Sagar A--CARDIOLOGY

**Consultants  
Anesthesiologi  
sts**

☐ **Diagnosis**

**Diagnosis**

Disease	Disease Type
.	

A TYPICAL CHEST PAIN  
CORONARY ARTERY DISEASE-TMT POSITIVE  
CORONARY ANGIOGRAM DONE ON 13/05/2022  
PLAN:MEDICAL MANAGEMENT

C/o chest pain since 2 months on and off a/w SOB on exertion

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 84/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 35 years old male patient Mr. JUPAKA RAJESH came with c/o chest pain since 2 months on and off a/w SOB on exertion. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SR, MILD LV DYSFUNCTION [EF-45%], R/F : ALCOHOLIC, CORONARY ANGIOGRAM (21/12/2021) -CAD-RCA mid moderate stenosis

PLAN MEDICAL MANAGEMENT . Patient is being discharged in hemodynamically stable condition with required medication and advise.

#### DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ROZAVEL 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB: CARDACE-H 2.5MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001021325

		<b>Name</b>	Mr. KASARAPUR RAMACHANDRAM	
<b>Patient Identifier</b>	ARHIP55728	<b>Age</b>	50Yr 1Mth 16Days	
<b>Sex</b>	Male	<b>Date of Admission</b>	15-May-2022	
<b>Date of Discharge</b>				
<b>MLC No</b>				
<b>Address</b>	KARIMNAGAR,Karimnagar,Telangana		<b>Ward/Bed No</b>	First Floor, MICU, Bed no:MICU 8
<b>Primary Consultant</b>	Dr Chandra Shekar Sathineni(MD (Internal			

**METABOLIC ENCEPHALOPATHY  
ALCOHOL WITHDRAWAL  
CVA**

C/o sudden weakness of right upper and lower limb associated with 2 episodes of vomitings and right side deviation of mouth  
H/o CAD

**AT ADMISSION:**

O/E patient is conscious, mild drowsy

Afebrile

PR: 73/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 50 years old male patient Mr. KASARAPUR RAMACHANDRAM came with c/o sudden weakness of right upper and lower limb associated with 2 episodes of vomitings and right side deviation of mouth, decreased urine output . All necessary investigations were done and diagnosed as METABOLIC ENCEPHALOPATHY, ALCOHOL WITHDRAWAL, CVA. Managed conservatively. Cardiologist and Neurophysician consultations taken and advice followed. Patient attendants requested for discharge, hence patient is being discharge at request and referred to higher center for further management.

DISCHARGE MEDICATION:

- 
- 1) TAB. ECOSPRIN GOLD 20 MG ONCE DAILY AT 2 PM FOR 5 DAYS
  - 2) TAB. LIBRIUM 10 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS
  - 3) TAB. BENFOMET FORTE ONCE DAILY AT 2 PM FOR 5 DAYS
  - 4) TAB. PAN-D 40MG ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001230708

**Patient Identifier**

ARHIP55718

**Sex**

Male

**Date of Discharge**

13-May-2022

**MLC No**

**Address**

MANDAMARRI,Telangana

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

**Surgeons**

Dr. Vidya Sagar A--CARDIOLOGY

**Name**

Mr. JUPAKA  
RAJESH

**Age**

35Yr 0Mth  
7Days

**Date of  
Admission**

13-May-  
2022

**Ward/Bed No**

Ground  
Floor,  
Emergenc  
y Ward,  
Bed  
no:EME 8

**Consultants  
Anesthesiologi  
sts**

Diagnosis

Diagnosis

Disease	Disease Type
A TYPICAL CHEST PAIN CORONARY ARTERY DISEASE-TMT POSITIVE CORONARY ANGIOGRAM DONE ON 13/05/2022 PLAN:MEDICAL MANAGEMENT.	

C/o chest pain, radiating to back since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 35 years old male patient Mr. JUPAKA RAJESH came with c/o chest pain, radiating to back since 1 day. All necessary investigations were done and diagnosed as A TYPICAL CHEST PAIN, CORONARY ARTERY DISEASE-TMT POSITIVE, CORONARY ANGIOGRAM DONE ON 13/05/2022, PLAN:MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN AV 75MG ONCE DAILY AFTER DINNER TO CONTINUE.

2. TAB. VELOZ 20 MG ONCE DAILY BEFORE BREAKFAST FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

ARH1.0001230822		<b>Name</b>	Mrs. POCHAMMA AKKAPAKA
<b>Patient Identifier</b>	ARHIP55709	<b>Age</b>	64Yr 0Mth 5Days
<b>Sex</b>	Female	<b>Date of Admission</b>	12- May- 2022
<b>Date of Discharge MLC No</b>			
<b>Address</b>	GODAVARIKANI,Ramagundam,Telangana	<b>Ward/Bed No</b>	First Floor, SICU, Bed no:SICU 2
<b>Primary Consultant</b>	Dr. GOUTHAM ROY (MS(General		

EPIGASTRIC HERNIA

SURGERY: OPEN EPIGASTRIC HERNIA REPAIR DONE ON 14.05.2022

C/o swelling over epigastric region

#### PHYSICAL EXAMINATION:

##### ON ADMISSION

-----

Pt c/c/c

afebrile

PR-80/min

BP-120/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

CNS-NAD.



SPO2-98%

A 64yr old female patient Mrs. POCHAMMA AKKAPAKA came with c/o swelling over epigastric region. All necessary investigations done and diagnosed as EPIGASTRIC HERNIA, SURGERY: OPEN EPIGASTRIC HERNIA REPAIR DONE ON 14.05.2022. Findings: Defect measuring 3 x 2 cm noted in the epigastric region omentum as its content. Pulmonologist consultation taken and advice followed. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 15 DAYS
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 5 DAYS.
2. TAB: SOMPRAZ-L TWICE DAILY AT 8AM, 8PM FOR 10 DAYS
5. GLUTAVAUULT SACHETS ONCE DAILY AT 2PM FOR 15 DAYS.
6. SPIROMETRY EXERCISES
7. AZEFLO NASAL SPRAY TWICE DAILY AT 8AM, 8PM FOR 15 DAYS  
AZEFLO NASAL SPRAY ONCE DAILY AT 8PM FOR 15 DAYS
8. TAB. MONTEK AB ONCE DAILY AT 8PM FOR 10 DAYS

Review after 7 days in General Surgery OPD.

ARH1.0001204623

**Name**

Mrs.  
KANDE  
LASMAKKA

**Patient Identifier**

ARHIP55601

**Age**

69Yr  
3Mth  
11Days

**Sex**

Female

**Date of Admission**

05-May-2022

**Date of Discharge  
MLC No**

**Address**

ladnapur,  
peddapally,,Karimnagar,Telangana

**Ward/  
Bed No**

First  
Floor,  
CT  
POST,  
Bed  
no:CT  
4

**Primary Consultant**

Dr SOMASHEKAR K(MS,MCH

S

CHRONIC RHEUMATOID HEART DISEASE WITH SEVERE MITRAL  
REGURGITATION, MVP WITH SEVERE MITRAL REGURGITATION +  
**CEREBRAL VASCULAR ACCIDENT, HYPERTENSION**  
SURGERY: MVR WITH SJ NO. 31 MM, MECHANICAL VALVE DONE ON 10/05/2022

C/o SOB on exertion a/w palpitations since 3 days

AT ADMISSION:

Afebrile

PR: 82/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 69 years old female patient Mrs. KANDE LASMAKKA came with c/o SOB on exertion a/w palpitations since 3 days. All necessary investigations were done and diagnosed as CHRONIC RHEUMATOID HEART DISEASE WITH SEVERE MITRAL REGURGITATION, ?MVP WITH SEVERE MITRAL REGURGITATION + **CEREBRAL VASCULAR ACCIDENT, HYPERTENSION**, SURGERY: MVR WITH SJ NO. 31 MM, MECHANICAL VALVE DONE ON 10/05/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, he is being discharged with required medication and advice.

POST MVR 2D ECHO REPORTS SHOWED POST MVR STATUS , PROSTHETIC VALVE INSITU, NO VALVULAR/ PARAVALVULAR LEAK, NORMAL FUNCTIONING PROSTHETIC MITRAL VALVE, MILD LV DYSFUNCTION. NO CLOT/PE/VEG

BMI is 20.2 kg/m<sup>2</sup>.

Sr. Creatinine report done on 11.05.2022 0.9 mg/dl

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ACITROM 1 MG ONCE DAILY AT 7PM TO CONTINUE FOR LIFE LONG.
- 2) TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. ND VIT ONCE DAILY AT 2 PM TO CONTINUE
- 4) TAB. CLOPILET -A 75+150 MG ONCE DAILY AT 2PM TO CONTINUE.
- 5) TAB. ROZAVEL 20 MG ONCE DAILY AT 2PM TO CONTINUE.
- 6) TAB. DIXIN 0.25 MG ONCE DAILY AT 2PM TO CONTINUE.
- 7) TAB. MET XL 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 8) TAB. CARDARONE 100 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 9) TAB. COLPOL 500MG THRICE DAILY AT 8AM, 2PM AND 8PM FOR 5 DAYS.
- 10)TAB. FAMOCID 40 MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.
- 11) TAB. LIZOLID 600 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD

## REVIEW AFTER 11 DAYS TO NEUROPHYSICIAN OPD

ARH1.0001230808

**Name**

Mrs.  
KASAM  
BHUMAKKA

**Patient Identifier** ARHIP55700

**Age** 80Yr  
0Mth  
6Days

**Sex** Female

**Date of Admission** 11-May-2022

**Date of Discharge**  
**MLC No**

**Address** KARIMNAGAR,Karimnagar,Telangana

**Ward/ Bed No** First Floor, MICU, Bed no:MICU 3

**Primary Consultant** DR. NIKHIL GOLI --NEUROLOGY

ACUTE AND CHRONIC SDH (LEFT > RIGHT)  
CONSERVATIVE MANAGEMENT

C/o sudden onset of right upper and lower limb since 2 days associated with slurring of speech and deviation of angle of mouth to left  
History of fever since 2 days

AT ADMISSION:

Patient conscious incoherent cooperative  
Febrile 101  
PR: 93/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 80 years old female patient Mrs. KASAM BHUMAKKA came with c/o sudden onset of right upper and lower limb since 2 days associated with slurring of speech and deviation of angle of mouth to left, history of fever since 2 days. All necessary investigations were done and diagnosed as ACUTE AND CHRONIC SDH LEFT MORE THAN RIGHT CONSERVATIVE MANAGEMENT. Patient attendants requested for discharge, hence patient is being discharge at request.

DISCHARGE MEDICATION:

- 
- 1) TAB. BENFOMET FORTE ONCE DAILY AT 2 PM FOR 5 DAYS
  - 2) TAB. PAN 40MG ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.
  - 3) SYP. GLYCEROL 2 TSP **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS.

REVIEW AFTER 5 DAYS IN GENERAL MEDICINE OPD

DR. SAI SURYA

55686

COMPLETE HEART BLOCK,  
NORMAL LV SYSTOLIC FUNCTION, EF-60%,  
TPI DONE ON 14/05/2022,

PERMANENT PACEMAKER IMPLANTATION DONE ON 14/05/2022 (MEDTRONIC VVIR) MODEL:S/N  
540026516G

AMPOXIN

55613

ARH1.0001230440

<b>Name</b>	Ms. J VIJAYA		
<b>Patient Identifier</b>	ARHIP55613	<b>Age</b>	46Yr 0Mth 17Days
<b>Sex</b>	Female	<b>Date of Admission</b>	06-May-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	GODAVARIKHANI ,Ramagundam,Telangana	<b>Ward/ Bed No</b>	First Floor, CT POST, Bed no:CT 2
<b>Primary Consultant</b>	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant		

SEVERE CALCIFIC AORTIC VALVE STENOSIS IN A BICUSPID VALVE RIGHT, HYPOTHYROIDISM SURGERY: AORTIC VALVE REPLACEMENT WITH SJ NO 17 MM MECHANICAL VALVE DONE ON 13/05/2022

C/o SOB on exertion a/w palpitations since 3 days

AT ADMISSION:

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft



A 46 years old female patient Mrs. VIJAYA came with c/o SOB on exertion a/w palpitations since 3 days. All necessary investigations were done and diagnosed as SEVERE CALCIFIC AORTIC VALVE STENOSIS IN A BICUSPID VALVE RIGHT, HYPOTHYROIDISM, SURGERY: AORTIC VALVE REPLACEMENT WITH SJ NO 17 MM MECHANICAL VALVE DONE ON 13/05/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, he is being discharged with required medication and advice.

POST AVR 2D ECHO REPORTS SHOWED POST MVR STATUS , PROSTHETIC VALVE INSITU, NO VALVULAR/ PARAVALVULAR LEAK, NORMAL LV FUNCTION. NO CLOT/PE/VEG

BMI is \_\_\_ kg/m<sup>2</sup>.

Sr. Creatinine report done on 14.05.2022 0.9 mg/dl

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ACITROM 1 MG & 2 MG ALTERNATE DAY AT 7PM TO CONTINUE FOR LIFE LONG.
- 2) TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. ND VIT ONCE DAILY AT 2 PM TO CONTINUE
- 4) TAB. THYRONORM 50 MG ONCE DAILY AT 7AM BBF TO CONTINUE.
- 5) TAB. MET XL 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 6) TAB. COLPOL 500MG THRICE DAILY AT 8AM, 2PM AND 8PM FOR 5 DAYS.
- 7)TAB. FAMOCID 40 MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD

ARH1.0001230967

**Name**

Mr. SHAIK  
ANWAR

**Patient  
Identifier**

ARHIP55753

**Age**

50Yr  
0Mth  
1Days

**Sex**

Male

**Date of  
Admission**

16-May-  
2022

**Date of  
Discharge  
MLC No**

**Address**

00,  
VILASNAGAR,JAYASHANKAR9394052728,Telanga  
na

**Ward/  
Bed No**

Second  
Floor,  
Male  
General  
Ward,  
Bed  
no:GW1  
7

**Primary  
Consultant**

DR. NIKHIL GOLI --NEUROLOGY

RIGHT MIDBRAIN INFARCT  
AF WITH CONTROLLED VR

-  
H/o diplopia since 3 days a/w giddiness  
known case of CAD  
S/P CABG 2010  
-

AT ADMISSION:

Afebrile

PR: 84/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 50 years old male patient Mr. SHAIK ANWAR came with h/o diplopia since 3 days a/w giddiness,  
known case of CAD, S/P CABG 2010. All necessary investigations were done and diagnosed as  
RIGHT MIDBRAIN INFARCT , AF WITH CONTROLLED VR. Managed conservatively. Patient  
condition and need for further hospitalization explained to patient attendants but  
they want to leave against medical advice, so patient being discharged under LAMA.

ARH1.0001230923

**Name**

Mr. RAMULU GADE

**Patient Identifier**

ARHIP55729

**Age**

65Yr  
0Mth  
3Days

**Sex**

Male

**Date of Admission**

15-May-2022

**Date of Discharge  
MLC No**

**Address**

SANGAMALLAIAH  
PALLE,Mancheria,Telangana

**Ward/  
Bed No**

First  
Floor,  
CICU ,  
Bed  
no:CICU  
9

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE IWMI, SR, NO TLT

MILD LV SYSTOLIC DYSFUNCTION, EF-45%

CORONARY ANGIOGRAM DONE ON 15/05/2022 - CAD-SVD (RCA)

PRIMARY PTCA+DES TO RCA WITH 3.5 X 18 MM XIENCE XPEDITION DONE ON 15/05/2022  
R/F: HYPERTENSION

C/o Retrosternal chest pain since 3 days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 65 years old male patient Mr. RAMULU GADE came with c/o retrosternal chest pain since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, SR, NO TLT, MILD LV SYSTOLIC DYSFUNCTION, EF-45%, CORONARY ANGIOGRAM DONE ON 15/05/2022 - CAD-SVD (RCA), PRIMARY PTCA+DES TO RCA WITH 3.5 X 18 MM XIENCE XPEDITION DONE ON 15/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. CILODOC 50MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 4) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. BETALOC 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 6) TAB. PANTOCID 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001093693

**Name**

Mrs.  
MAHEMOODA  
BEGUM

**Patient  
Identifier**

ARHIP55746

**Age**

81Yr  
6Mth  
6Days

**Sex**

Female

**Date of  
Admission**

16-May-  
2022

**Date of  
Discharge  
MLC No**

17-May-2022

**Address**

KAKATIYA COLONY, Warangal, Telangana

**Ward/Bed No**

First  
Floor,  
CICU ,  
Bed  
no: CICU  
2

**Primary  
Consultant  
Surgeons**

Dr. Vidya Sagar A--CARDIOLOGY

**Consultants  
Anesthesiologi  
sts**

**Diagnosis**

Diagnosis

Disease	Disease Type
.	

ACUTE KIDNEY INJURY WITH HPERKALEMIA

C/o shortness of breath grade-3 since few days, drowsiness+

AT ADMISSION:

Afebrile

PR: 80/min

BP: 130/870mmHg

RS: BAE+

CVS: S1S2

RR: 17/min

SPO2: 98%

P/A: Soft

A 81 years old female patient Mrs. MAHEMOODA BEGUM came with c/o shortness of breath grade-3 since few days, drowsiness+. All necessary investigations were done and diagnosed as ACUTE KIDNEY INJURY WITH HPERKALEMIA. Managed conservatively. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA.

APJ1.0016600148		<b>Name</b>	Mr. VELPUR SACHIN
<b>Patient Identifier</b>	ARHIP55738	<b>Age</b>	29Yr 3Mth 11Days
<b>Sex</b>	Male	<b>Date of Admission</b>	16-May-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	FLOT NO: 102, SRI SAI LAXMI APARTMENTS, GANGASTAN PHASE 1,Nizamabad,Telangana	<b>Ward/Bed No</b>	First Floor, SICU, Bed no:SICU 5
<b>Primary Consultant</b>	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)--GENERAL SURGERY	<b>Consultants</b>	
<b>Surgeons</b>	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)--GENERAL SURGERY	<b>Anesthesiologists</b>	Dr Subba Reddy Kuppannagari--ANAESTHESIOLOGY

Diagnosis

Diagnosis

[Add Diagnosis](#)

ARHIP55738	APJ 1.001660014
------------	-----------------

Surgery / Procedures Done

Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
LIFT(LIGATION OF INTERSHINECTERIC FISTULOUS TRACT)				



INTERSPHINCTERIC FISSURE IN ANO  
SURGERY: LIFT(LIGATION OF INTERSPHINCTERIC FISTULOUS TRACT) DONE ON 13/05/22

C/o pain and discharge around the anus

#### PHYSICAL EXAMINATION:

##### ON ADMISSION

-----

Pt c/c/c

afebrile

PR-81/min

BP-110/70mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

SPO2-98%

A 29 yrs old male patient Mr. VELPUR SACHIN came with c/o pain and discharge around the anus. All necessary investigations done and diagnosed as INTERSPHINCTERIC FISSURE IN ANO, SURGERY: LIFT(LIGATION OF INTERSHINCTERIC FISTULOUS TRACT) DONE ON 13/05/22. Findings: Small tract measuring 2 cm with rectal opening at 7 o'clock position and inferior opening at 6 o'clock. Post operative period was uneventful. Neurophysician consultation taken and advice followed. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. METROGYL-P OINTMENT L/A THRICE DAILY
4. XYLOCAINE JELLY EVERY 4<sup>th</sup> hrly
5. TAB: ND PAIN **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS.
6. SITZ BATH TWICE DAILY
7. SYP. LACTIHEP 3 TSP ONCE IN A DAY AT 8 PM
8. GLUTAVALT SACHETS ONCE DAILY AT 8AM WITH GLASS OF WATER FOR 15 DAYS.
9. TAB: MAXMALA 50 MG ONCE DAILY AT 8PM FOR 10 DAYS
10. TAB: ND Q10 ONCE DAILY AT 8PM FOR 10 DAYS

Review after 7 days in General Surgery OPD.



ARH1.0001230775

<b>Name</b>	Mrs. ISHRATH PARVEEN		
<b>Patient Identifier</b>	ARHIP55689	<b>Age</b>	42Yr 0Mth 3Days
<b>Sex</b>	Female	<b>Date of Admission</b>	11-May-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	6-6-425, SHARMANAGAR, Karimnagar, Telangana	<b>Ward/ Bed No</b>	First Floor, CICU , Bed no: CICU12
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, AWTMI, SR

THROMBOLIZATION WITH INJ. TENETAPLACE (OUTSIDE)

SEVERE LV DYSFUNCTION [EF-35%]

CORONARY ANGIOGRAM DONE ON 16/05/2022 - CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.5 X 23 MM PRONOVA DONE ON 16/05/2022  
R/F : HTN

C/o chest pain, SOB with profuse sweating 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 42 years old female patient Mrs. ISHRATH PARVEEN came with c/o chest pain, SOB with profuse sweating 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWTMI, SR, THROMBOLIZATION WITH INJ. TENETAPLACE (OUTSIDE), SEVERE LV DYSFUNCTION [EF-35%], CORONARY ANGIOGRAM DONE ON 16/05/2022 - CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.5 X 23 MM PRONOVA DONE ON 16/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
3. TAB. CILODOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
4. TAB. ROSEDAY 40MG ONCE DAILY AT 8PM TO CONTINUE.
5. TAB. LOSAR 25 MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. BETALOC 25 MG ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS.
8. TAB. THYRONORM 75 MCG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001230930

**Name**

Mrs. SAI ALLA  
LAXMI

**Patient  
Identifier**

ARHIP55734

**Age**

49Yr  
0Mth  
3Days

**Sex**

Female

**Date of  
Admission**

15-May-  
2022

**Date of  
Discharge  
MLC No**

**Address**

H.NO:10-  
25,CHIMALAPETA,JULAPALLY,PEDDAPALLY,Other,Telanga  
na

**Ward/  
Bed No**

First  
Floor,  
MICU,  
Bed  
no:MIC  
U 8

**Primary  
Consultant**

Dr Chandra Shekar Sathineni

ACUTE GASTROENTERITIS  
URINARY TRACT INFECTION

C/o pain abdomen since 1 day associated with 3 episodes of vomitings

AT ADMISSION:

Afebrile

PR: 80/min

BP: 170/100mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft

A 49 years old female patient Mrs. SAI ALLA LAXMI came with c/o pain abdomen since 1 day associated with 3 episodes of vomitings. All necessary investigations were done and diagnosed as ACUTE GASTROENTERITIS, URINARY TRACT INFECTION. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

- 1) TAB. FPM ACT 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 2) TAB. LINOZEM TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 3) TAB. CALPOL 500 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 4) TAB. PAN 40 MG ONCE DAILY AT 7AM FOR 7 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001231074

**Name**

Mr.  
SRINIVAS  
RAO  
CHERUKURI

**Patient Identifier**

ARHIP55790

**Age** 52Yr 8Mth  
10Days

**Sex**

Male

**Date of Admission** 19-May-2022

**Date of Discharge**

**MLC No**

**Address**

RAMNAGAR KMR,Karimnagar,Telangana

**Ward/Bed No** First Floor, CICU ,  
Bed no:CICU11

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE AWMI, SR, NO TLT

MODERATE LV SYSTOLIC DYSFUNCTION [EF-35%]

S/P: CORONARY ANGIOGRAM (23.05.2015) DONE OUTSIDE- Triple Vessel Disease (LAD Mid Total Occlusion, LCX-> Major OM - 80% Stenosis, RCA- Proximal - 90% Stenosis)

Primary PCI + Stents to Mid LAD (Xience- V 2.75 x 23 mm).

RCA (Xience Pro 3.5 x 28 mm)

Elective PTCA (25.05.2015) + Stent To LCX (Xience Xpedition 3.0 x 38 mm),

Atypical Chest Pain- Trop T Negative (29.07.2015)

Check- CAG (10.08.2015)

CORONARY ANGIOGRAM (19/05/2022) -CAD-TVD, MILD ISR IN LAD, LCX, RCA STENTS

PLAN MEDICAL MANAGEMENT FOR D2 (THIN VESSEL) OSTIAL DISEASE

R/F : HTN, T2DM

C/o Sudden onset chest pain a/w SOB since 1 day

AT ADMISSION:



Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 52 years old male patient Mr. SRINIVAS RAO CHERUKURI came with c/o Sudden onset chest pain a/w SOB since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, SR, NO TLT, MODERATE LV SYSTOLIC DYSFUNCTION [EF-35%], S/P: CORONARY ANGIOGRAM (23.05.2015) DONE OUTSIDE- Triple Vessel Disease (LAD Mid Total Occlusion, LCX-> Major OM - 80% Stenosis, RCA- Proximal - 90% Stenosis), Primary PCI + Stents to Mid LAD (Xience- V 2.75 x 23 mm), RCA (Xience Pro 3.5 x 28 mm), Elective PTCA (25.05.2015) + Stent To LCX (Xience Xpedition 3.0 x 38 mm), Atypical Chest Pain- Trop T Negative (29.07.2015), Check- CAG (10.08.2015), CORONARY ANGIOGRAM (19/05/2022) -CAD-TVD, MILD ISR IN LAD, LCX, RCA STENTS , PLAN MEDICAL MANAGEMENT FOR D2 (THIN VESSEL) OSTIAL DISEASE. Patient is being discharged in hemodynamically stable condition with required medication and advise.

#### DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. AX CER 90MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. PROLOMET XL 25MG ONCE DAILY AT 8AM TO CONTINUE.

5. TAB. COVANCE 25MG ONCE DAILY AT 8AM TO CONTINUE.

6. TAB. ANGISPAN TR 2.5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

7. TAB: VELOZ 20MG ONCE DAILY AT 8AM TO CONTINUE.

ADV: LIFE STYLE MODIFICATIONS

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0001231024

**Name**

Mrs. B VIMALA

**Patient Identifier**

ARHIP55760

**Age**

56Yr  
0Mth  
3Days

**Sex**

Female

**Date of Admission**

17-May-2022

**Date of Discharge  
MLC No**

**Address**

katlakunta, jagityal,Karimnagar,Telangana

**Ward/  
Bed No**

First  
Floor,  
CICU ,  
Bed  
no:CICU  
2

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE IWMI, NO TLT, SR

MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%

CORONARY ANGIOGRAM DONE ON 17/05/2022 - CAD-DVD (RCA, LAD)

PRIMARY PTCA+DES TO RCA WITH XIENCE XPEDITION 4.0 X 18 MM, LAD WITH XIENCE XPEDITION 3.0 X 15 MM DONE ON 17/05/2022

C/o chest pain since 1 day associated with shortness of breath

AT ADMISSION:

Patient is conscious and coherent  
Afebrile

PR: 80/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 56 years old female patient Mrs. B VIMALA came with c/o chest pain since 1 day associated with shortness of breath. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%, CORONARY ANGIOGRAM DONE ON 17/05/2022 - CAD-DVD (RCA, LAD), PRIMARY PTCA+DES TO RCA WITH XIENCE XPEDITION 4.0 X 18 MM, LAD WITH XIENCE XPEDITION 3.0 X 15 MM [LOT NO: 1062241, S/N :1070300-15], [LOT NO: 1032541, S/N : 1070400-18] DONE ON 17/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. AXCER 90MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. ROZAVEL 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. PANTOCID 40MG ONCE DAILY AT 7AM FOR 10 DAYS.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

55763

ARH1.0001231025

Name

Mrs. M A  
BADRUNNISA

Patient  
Identifier

ARHIP55763

Age

67Yr  
0Mth  
0Days

Sex

Female

Date of  
Admission

17-  
May-  
2022

Expired Date  
MLC No

17-May-2022

Address

ELLANTHAKUNTA,Karimnagar,Telangana

Ward/Bed No

First  
Floor,  
HDU,  
Bed  
no:HD  
U 11

Primary  
Consultant

Dr. Vidya Sagar A--CARDIOLOGY

Consultants

Surgeons

Dr. Vidya Sagar A--CARDIOLOGY

Anesthesiologi  
sts

Diagnosis  
S

Diagnosis

Disease	Disease Type
A TYPICAL CHEST PAIN CORONARY ARETERY DISEASE ACUTE ANTERIOR WALL MYOCARDIAL INFARCTION CORONARY ANGIOGRAM AND PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASY TO D2 AND OM1 DONE ON 17/5/2022.	

ARH1.0001231025

Name

Mrs. M A  
BADRUNNISA

Patient Identifier

ARHIP55763

Age

67Yr  
0Mth  
1Days

Sex

Female

Date of  
Admission

17-  
May-  
2022

Date of Discharge  
MLC No

Address

ELLANTHAKUNTA,Karimnagar,Telangana

Ward/Bed  
No

First  
Floor,  
HDU,  
Bed  
no:HD  
U 11

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

C/o chest pain since 1 day

AT ADMISSION:

PR: 90/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 67 years old female patient Mrs. M A BADRUNNISA came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as A TYPICAL CHEST PAIN CORONARY ARETERY DISEASE ACUTE ANTERIOR WALL MYOCARDIAL INFARCTION CORONARY ANGIOGRAM AND PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASY TO D2 AND OM1 DONE ON 17/5/2022. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and ionotropic support was given. CPR started immediately, continued for 40 minutes, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 09.15 PM on 17/05/2022.

#### CAUSE OF DEATH

-----

SUDDEN CARDIOPULMONARY ARREST SECONDARY TO ATYPICAL CHEST PAIN, MYOCARDIAL INFARCTION

ARH1.0001230962

**Name**

Mr. K  
PRABHAKAR

**Patient Identifier**

ARHIP55747

**Age**

65Yr  
0Mth  
5Days

**Sex**

Male

**Date of Admission** 16-May-2022

**Date of Discharge**

**MLC No**

**Address**

Sulthanabad,Karimnagar,Telangana

**Ward/Bed No**

First  
Floor,  
CICU ,  
Bed  
no:CICU  
8

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%

CORONARY ANGIOGRAM DONE ON 18/05/2022 - CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.0 X 32 MM METAFOR DONE ON 18/05/2022  
R/F: HTN, T2DM

C/o chest pain since few days

AT ADMISSION:

Afebrile

PR: 85/min

BP: 100/70 mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft



A 65 years old male patient Mr. PRABHAKAR came with c/o chest pain since few days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%, CORONARY ANGIOGRAM DONE ON 18/05/2022 - CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.0 X 32 MM METAFOR DONE ON 18/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASUDOC 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. SARTEL 40 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. FRUSELAC ONCE DAILY AT 2PM TO CONTINUE.
- 6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001230927

		Mr. GOPAL KISHAN RAO	
<b>Patient Identifier</b>	ARHIP55733	<b>Age</b>	73Yr 0Mth 6Days
		<b>Date of Admission</b>	15-May-2022
<b>Sex</b>	Male		
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	H.NO:118,BRAHMANDWADA (RAMNAGAR) TANDUR,MANCHIRIAL,Other,Telangana		<b>Ward/Bed No</b> First Floor, MICU, Bed no:MICU 1
<b>Primary Consultant</b>	Dr Chandra Shekar Sathineni		

UROSEPSIS  
ALZHEIMER'S DISEASE  
DIABETIC MELLITUS

C/o fever since 4 days associated with dysuria, burning micturition  
Known case of Alzheimer's Disease

AT ADMISSION:

Afebrile

PR: 78/min

BP: 140/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 73 years old male patient Mr. GOPAL KISHAN RAO came with c/o fever since 4 days associated with dysuria, burning micturition. Known case of Alzheimer's Disease. All necessary investigations were done and diagnosed as UROSEPSIS, ALZHEIMER'S DISEASE, DIABETIC MELLITUS. Managed conservatively. Patient attendants requested for discharge, hence patient is being discharge at request.

DISCHARGE MEDICATION:

- 
- 1) TAB. FPM ACT 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
  - 2) TAB. LINOZEM 600 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
  - 3) TAB. RAZO-L ONCE DAILY AT 8AM FOR 10 DAYS
  - 4) TAB. OXRA MET ONCE DAILY AT 2PM FOR 10 DAYS
  - 5) INJ. TOUJEO 20 Units ONCE DAILY AT 8PM TO CONTINUE
  - 6) TAB. GLUCO Q10 ONCE DAILY AT 2PM FOR 10 DAYS
  - 7) TAB. ARVAST CV ONCE DAILY AT 8PM FOR 10 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001231131

**Name** Mr.  
GUGGILLA  
LACHAIAH

**Patient Identifier** ARHIP55812

**Age** 69Yr  
4Mth  
1Days

**Sex** Male

**Date of Admission** 20-May-2022

**Date of Discharge** 20-May-2022

**MLC No**

**Address** 21-73,  
RAMKISTAPUR,JAGTIAL,Karimnagar,Telanga  
na

**Ward/Bed No** First  
Floor,  
CICU ,  
Bed  
no:CICU  
9

**Primary Consultant** Dr. Vidya Sagar A--CARDIOLOGY

**Consultants**

**Surgeons**

**Anesthesiologists**

## Diagnosis

### Diagnosis

[Add Diagnosis](#)

Disease	Disease Type
CORONARY ARTERY DISEASE NSTEMI, NO TLT SR, SEVERE LV SYSTOLIC DYSFUNCTION EF:30%. PLAN :CORONARY ANGIOGRAM	

C/o Chest pain since 20 days, difficulty in breathing

### PHYSICAL EXAMINATION:

#### ON ADMISSION

-----

Patient c/c

PR-131/min

BP-100/60mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

P/A-Soft

SPO2-60% on 10 Litr O2

A 69 yrs old male patient GUGGILLA LACHAIAH came with c/o Chest pain since 20 days, difficulty in breathing. All necessary investigations done and diagnosed as CORONARY ARTERY DISEASE NSTEMI, NO TLT, SR, SEVERE LV SYSTOLIC DYSFUNCTION EF:30%, PLAN :CORONARY ANGIOGRAM. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA.

ARH1.0001204257

**Name**

Mrs. N  
PADMA

**Patient Identifier**

ARHIP55758

**Age**

50Yr  
3Mth  
21Days

**Sex**

Female

**Date of  
Admission**

17-May-  
2022

**Date of Discharge  
MLC No**

**Address**

karimnagar,Karimnagar,Telangana

**Ward/  
Bed No**

First  
Floor,  
CICU ,  
Bed  
no:CICU  
4

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, UNSTABLE ANGINA

SEVERE LV SYSTOLIC DYSFUNCTION [EF-30%]

DRUG INDUCED HYPERKALEMIA

K/C/O DCMF

R/F : HTN, DM

REFER TO HIGHER CENTER

C/o chest pain on and off since few days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 80/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 50 years old female patient Mrs. N PADMA came with c/o chest pain on and off since few days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SEVERE LV SYSTOLIC DYSFUNCTION [EF-30%], DRUG INDUCED HYPERKALEMIA , K/C/O DCMP, R/F : HTN, DM , REFER TO HIGHER CENTER . Patient is referred to higher center for further management, hence patient is being discharged with required medication and advise.

#### DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 75 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. BISONEX 5 MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. IVABRAD 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. ISOLANINE **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. INJ HUMAN MIXTURED 30/70 30 Units AT 8AM 15 Units AT 8PM CONTINUE
8. INJ LASIX 40 MG ONCE DAILY AT 2PM TO CONTINUE.
9. TAB. SOBINIX 500 MG ONCE DAILY AT 2PM TO CONTINUE.
10. K-BIND SACHETS with glass of water 3<sup>rd</sup> hrly

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS



ARH1.0001231071

		Mr. KHAZI MOHAMMADASHWAQ E ALI	
<b>Patient Identifier</b>	ARHIP55787	<b>Age</b>	68Yr 4Mth 3Days
<b>Sex</b>	Male	<b>Date of Admission</b>	18-May-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	5-4-191, KHAZI PURA,JAGTIAL,Karimnagar,Telangana	<b>Ward/ Bed No</b>	First Floor, CICU , Bed no:CICU1 2
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE AWMI

MILD LV SYSTOLIC DYSFUNCTION, EF-50%

CORONARY ANGIOGRAM DONE ON 18/05/2022 - CAD-SVD (LAD)

PRIMARY PTCA+DES TO LAD WITH 3.0 X 32 MM METAFOR DONE ON 18/05/2022  
R/F: T2DM

C/o chest pain since 2days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 68 years old male patient Mr. KHAZI MOHAMMADASHWAQE ALI came with c/o chest pain since 2days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWTMI, MILD LV SYSTOLIC DYSFUNCTION, EF-50%, CORONARY ANGIOGRAM DONE ON 18/05/2022 - CAD-SVD (LAD), PRIMARY PTCA+DES TO LAD WITH 3.0 X 32 MM METAFOR DONE ON 18/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. CILODOC 50MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 4) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. GLYCOMET SR 500 MG ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001219310

**Name**

Mr. ODELU  
BANDARI

**Patient Identifier**

ARHIP55722

**Age**

61Yr  
9Mth  
11Days

**Sex**

Male

**Date of  
Admission**

14-May-  
2022

**Date of Discharge  
MLC No**

**Address**

H.NO:14-4-506,VITAL  
NAGAR,GODHAVARIKHANI,PEDDAPALLY,Other,Telanga  
na

**Ward/  
Bed No**

First  
Floor,  
CICU ,  
Bed  
no:CICU  
1

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

ACUTE LVF

SEVERE LV SYSTOLIC DYSFUNCTION [EF-25%]

CORONARY ARTERY DISEASE

S/P CABG [2017]

EXTERNAL HAEMORRHOIDECTOMY [20/07/21]  
DEBRIDEMENT WITH A HYSTEROSCOPY [20/01/22]  
K/C/O ADHF

R/F : HTN, T2DM

C/o shortness of breath grade-IV associated with profuse sweating since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 94/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft

A 61 years old male patient Mr. ODELU BANDARI came with c/o shortness of breath grade-IV associated with profuse sweating since 1 day. All necessary investigations were done and diagnosed as ACUTE LVF, SEVERE LV SYSTOLIC DYSFUNCTION [EF-25%], CORONARY ARTERY DISEASE, S/P CABG [2017], EXTERNAL HAEMORRHOIDECTOMY [20/07/21], DEBRIDEMENT WITH A HYSTEROSCOPY [20/01/22], K/C/O ADHF, R/F : HTN, T2DM. Patient is being discharged in hemodynamically stable condition with required medication and advise.

#### DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPITAB 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB: CARDIVAS 3.125MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB: FRUSELAC DS ONCE DAILY AT 8AM TO CONTINUE.
6. TAB: CIDMUS 100MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB: PYRIDIUM 200MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
8. HOME OXYGEN SUPPORT

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH FBS, PLBS, RFT REPORTS

ARH1.0001231018

**Name**

Mrs.  
RUKUM BAI  
DURGAM

**Patient Identifier**

ARHIP55768

**Age** 55Yr 0Mth  
4Days

**Sex**

Female

**Date of Admission** 17-May-2022

**Date of Discharge**

**MLC No**

**Address**

POTHPALLE,Tandur,Telangana

**Ward/Bed No** First  
Floor,  
CICU ,  
Bed  
no:CICU1  
0

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE ANTERIOR WALL MYOCARDIAL INFARCTION

SEVERE LV SYSTOLIC DYSFUNCTION [EF-30%]

CORONARY ANGIOGRAM (21/05/2022) -CAD-SVD [LAD- Recanalized]

PLAN MEDICAL MANAGEMENT

C/o chest pain a/w mild SOB, sweating since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 83/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 55 years old female patient Mrs. RUKUM BAI DURGAM came with c/o chest pain a/w mild SOB, sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE ANTERIOR WALL MYOCARDIAL INFARCTION, SEVERE LV SYSTOLIC DYSFUNCTION [EF-30%], CORONARY ANGIOGRAM (21/05/2022) -CAD-SVD [LAD- Recanalized], PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001231041

**Name**

Mr. TURKA  
PAPI  
REDDY ..

**Patient Identifier**

ARHIP55788

**Age**

40Yr  
0Mth  
3Days

**Sex**

Male

**Date of Admission**

18-  
May-  
2022

**Date of Discharge  
MLC No**

**Address**

komatikondapur,jagityal,Karimnagar,Telangan

**Ward/  
Bed No**

Second  
Floor,  
Male  
General Ward,  
Bed  
no:GW  
20

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

ATYPICAL CHEST PAIN, LBBB, SR,  
MODERATE LV SYSTOLIC DYSFUNCTION  
R/F: HYPERTENSION  
CORONARY ANGIOGRAM (21/05/2022) -NORMAL CORONARIES

ADV: MEDICAL MANAGEMENT

C/o chest pain, difficulty in breathing since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft



A 40 years old male patient Mr. TURKA PAPI REDDY came with c/o chest pain, difficulty in breathing since 1 day. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN, LBBB, SR, MODERATE LV SYSTOLIC DYSFUNCTION, R/F: HYPERTENSION, CORONARY ANGIOGRAM (21/05/2022) -NORMAL CORONARIES, ADV: MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. TELMA 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001230962

**Name**

Mr. K PRABHAKAR

**Patient Identifier**

ARHIP55747

**Age**

65Yr  
0Mth  
5Days

**Sex**

Male

**Date of Admission**

16-May-2022

**Date of Discharge  
MLC No**

**Address**

Sulthanabad,Karimnagar,Telangana

**Ward/  
Bed No**

First  
Floor,  
CICU ,  
Bed  
no:CICU  
8

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

MODERATE LV SYSTOLIC DYSFUNCTION, EF-38%

CORONARY ANGIOGRAM DONE ON 18/05/2022 - CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.0 X 32 MM METAFOR DONE ON 18/05/2022  
R/F: HTN, T2DM

C/o chest pain since few days

AT ADMISSION:

Afebrile

PR: 85/min

BP: 100/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 65 years old male patient Mr. PRABHAKAR came with c/o chest pain since few days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-38%, CORONARY ANGIOGRAM DONE ON 18/05/2022 - CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.0 X 32 MM METAFOR DONE ON 18/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. TELSAN 40 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. GLYCOMET SR 500 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 6) TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 10 DAYS
- 7) SYP. ASCORYL-D 2 tsp **THRICE IN A DAY AT 8 AM 2 PM 8 PM**

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001231057

		Mrs. MANTHANI THARA	
<b>Patient Identifier</b>	ARHIP55779	<b>Age</b>	51Yr 0Mth 3Days
<b>Sex</b>	Female	<b>Date of Admission</b>	18-May-2022
<b>Date of Discharge MLC No</b>			
<b>Address</b>	7- 93,MANTHANI,PEDDAPALLI,Karimnagar,Telangana	<b>Ward/ Bed No</b>	First Floor, CICU , Bed no:CICU1 3
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE-ACUTE INFERIOR WALL MYOCARDIAL INFARCTION

NORMAL LV SYSTOLIC DYSFUNCTION EF:60%.

CORONARY ANGIOGRAM DONE ON 18/05/2022 - CAD-TVD [LAD, LCX, RCA]

PRIMARY PTCA+DES TO RCA (2 STENTS) WITH 3V ASTRA 3.0 X 24 MM & METAFOR 4.0 X 16 MM DONE ON 18/05/2022  
PLAN CABG LATER

R/F: HTN, T2DM

C/o chest pain a/w vomiting since 1 day

AT ADMISSION:

Afebrile

PR: 94/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 100%

P/A: Soft

A 51 years old female patient Mrs. MANTHANI THARA came with c/o chest pain a/w vomiting since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE-ACUTE INFERIOR WALL MYOCARDIAL INFARCTION, NORMAL LV SYSTOLIC DYSFUNCTION EF:60%, CORONARY ANGIOGRAM DONE ON 18/05/2022 - CAD-TVD [LAD, LCX, RCA], PRIMARY PTCA+DES TO RCA (2 STENTS) WITH 3V ASTRA 3.0 X 24 MM & METAFOR 4.0 X 16 MM DONE ON 18/05/2022, PLAN CABG LATER, R/F: HTN, T2DM. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. CILODOC 50MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 4) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. GLYCOMET SR 500MG ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. METOLAR XT 25MG ONCE DAILY AT 8AM TO CONTINUE.
- 7)TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

55667

LAXMINARSAVVA

ARH1.0001229629		<b>Name</b>	Mrs. LAXMI NARSAVVA KADAVA
<b>Patient Identifier</b>	ARHIP55663	<b>Age</b>	70Yr 1Mth 18Days
<b>Sex</b>	Female	<b>Date of Admission</b>	09-May-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	NALLAGONDA, KODIMIAL,JAGITIAL,Karimnagar,Telangana	<b>Ward/ Bed No</b>	First Floor, CT POST, Bed no:CT 1
<b>Primary Consultant</b>	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant-Cardio Thoracic & Vascular Surgeon)--C T SURGERY		

SEVERE MR WITH MYXOMATOUS DEGENERATION OF MV LEAVLET  
SURGERY: MVR WITH SJ NO. 27 MM, MECHANICAL VALVE DONE ON 17/05/2022

C/o SOB on exertion a/w palpitations since 3 days

AT ADMISSION:

Afebrile

PR: 82/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft



A 70 years old female patient Mrs. LAXMINARSAVVA came with c/o SOB on exertion a/w palpitations since 3 days. All necessary investigations were done and diagnosed as SEVERE MR WITH MYXOMATOUS DEGENERATION OF MV LEAVLET, SURGERY: MVR WITH SJ NO. 27 MM, MECHANICAL VALVE DONE ON 17/05/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, he is being discharged with required medication and advice.

POST MVR 2D ECHO REPORTS SHOWED POST MVR STATUS , PROSTHETIC VALVE INSITU, NO VALVULAR/ PARAVALVULAR LEAK, MILD LV DYSFUNCTION. NO CLOT/PE/VEG

BMI is 20.3 kg/m<sup>2</sup>.

Sr. Creatinine report done on 18.05.2022 1.0 mg/dl

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ACITROM 1 MG ONCE DAILY AT 7PM TO CONTINUE FOR LIFE LONG.
- 2) TAB. DYTOR PLUS 5 MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. ND VIT ONCE DAILY AT 2 PM TO CONTINUE
- 4) TAB. COLPOL 500MG THRICE DAILY AT 8AM, 2PM AND 8PM FOR 5 DAYS.
- 5) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.
- 6) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.
- 7) TAB. ALPRAX 0.25 MG ONCE DAILY AT 8PM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD

55817

ARH1.0001222967

<b>Name</b>	Mrs. JAMEELA BEE
<b>Patient Identifier</b>	ARHIP55817
<b>Age</b>	64Yr 7Mth 3Days
<b>Sex</b>	Female
<b>Date of Admission</b>	21-May-2022
<b>Date of Discharge</b>	
<b>MLC No</b>	
<b>Address</b>	DHARUR, JAGITIAL, Karimnagar, Telangana
<b>Ward/ Bed No</b>	First Floor, MICU, Bed no: MICU 1
<b>Primary Consultant</b>	Dr Chandra Shekar Sathineni

NEUROGLYCOPENIA,  
ANEMIA,  
DIABETIC MELLITUS

C/o unresponsiveness since 1 hour prior to arrival hospital

Known case of hypertension and diabetic mellitus

AT ADMISSION:

Patient is drowsy  
PR: 80/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 19/min

SPO2: 98%

P/A: Soft

A 64 years old female patient JAMEELA BEE came with c/o unresponsiveness since 1 hour prior to arrival hospital. Known case of hypertension and diabetic mellitus. All necessary investigations were done and diagnosed as NEUROGLYCOPENIA, ANEMIA, DIABETIC MELLITUS. Managed conservatively. 1 units of PCV transfusion given. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

- 1) TAB. DYTOR PLUS 10 MG ONCE DAILY AT 2PM FOR 5 DAYS
- 2) TAB. PROLOMET R ONCE DAILY AT 8AM FOR 5 DAYS
- 3) TAB. ECOSPRIN -AV 150/10 ONCE DAILY AT 2PM FOR 5 DAYS
- 4) TAB. GLUCO Q10 ONCE DAILY AT 2PM FOR 5 DAYS

REVIEW AFTER 5 DAYS IN GENERAL MEDICINE OPD

[10:06 am, 23/05/2022] Dmo Sw: Guillain-Barre syndrome

Pt presented with weakness of bilateral upper and lower limbs LL>UL

Trunkal weakness , unable to roll on the bed,,

Not able to stand from squatting position

On examination pt had

Quadriparesis,

Bilateral deep tendon reflexes absent

Vitals -----

Pt presented with

All the necessary investigations were done

Nerve conduction studies were done which showed reduced Bilateral median and ulnar compound action potential and prolonged F wave latencies in Bilateral median, ulnar and Tibial nerves ....  
diagnosed as a case of

Guillain-Barré syndrome

Intravenous methylprednisolone was given along with other supportive measures and physiotherapy

Pt improved symptomatically, hence now pt is being discharged in a hemodynamically stable condition with all the required medications and advice

Review after 10 days

[10:11 am, 23/05/2022] Dmo Sw: Medicine tab gabantip at 300/10. Cap rejunex cd3 1od for 10 days.

ARH1.00011062 05	ARHIP557 67	Mrs. TURAGA HANMAVVA   Female   75Yr 11Mth 25Days	GW 5	17-May- 2022	Dr. SURESH GOUD S
---------------------	----------------	--	---------	-----------------	----------------------

5-94,PAIDIMADUGU,Karimnagar,Telangana

VESICAL CALCULUS

SURGERY: CYSTOLITHOTRIPSY DONE ON 19/05/2022

C/o pain abdomen associated with burning micturation

ON ADMISSION

-----

Pt c/c/c

Afebrile

PR-80/min

BP-110/70mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

A 75 yrs old female patient Mrs. TURAGA HANMAVVA came to hospital with c/o pain abdomen associated with burning micturation . All necessary investigations done and diagnosed as VESICAL CALCULUS, SURGERY: CYSTOLITHOTRIPSY DONE ON 19/05/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

1. TAB: ROXSAFE CV 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: FAMOCID 40 MG ONCE DAILY AT 8AM FOR 11 DAYS.
4. TAB: ND Q10 ONCE DAILY AT 2PM FOR 11 DAYS.

REVIEW AFTER 11 DAYS TO UROLOGY OPD.

APJ1.0001475650

**Name**

Mrs.  
KOMAMARAMMA  
CH

**Patient Identifier**

ARHIP55723

**Age**

70Yr  
0Mth  
18Days

**Sex**

Female

**Date of  
Admission**

14-  
May-  
2022

**Date of Discharge  
MLC No**

**Address**

10-4-216,  
VAVILAPALLY,Karimnagar,Telangana

**Ward/Bed No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:111  
B

**Primary Consultant**

Dr Chandra Shekar Sathineni

SEPSIS  
ACUTE PULMONARY OEDEMA  
DIABETES MELLITUS  
CORONARY ARTERY DISEASE ON MEDICAL MANAGEMENT

C/o Shortness of breath grade III since 1 day associated with mild cough

AT ADMISSION:

Afebrile

PR: 94/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 23/min

SPO2: 98%

P/A: Soft

A 70 years old female patient Mrs. KOMAMARAMMA CH came with c/o Shortness of breath grade III since 1 day associated with mild cough. All necessary investigations were done and diagnosed as SEPSIS, ACUTE PULMONARY OEDEMA, DIABETES MELLITUS, CORONARY ARTERY DISEASE ON MEDICAL MANAGEMENT. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

- 1) TAB. FPM ACT 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 2) TAB. LINOZEM 600 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 3) TAB. PULMOCLEAR TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 4) TAB. BILAHENZE M ONCE DAILY AT 8PM FOR 7 DAYS
- 5) TAB. DAPEFY 10 MG ONCE DAILY AT 2PM FOR 7 DAYS
- 6) TAB. LIPCURE GOLD ONCE DAILY AT 8PM FOR 7 DAYS
- 7) TAB. FRUSELAC DS ONCE DAILY AT 8PM FOR 7 DAYS
- 8) TAB. DILZEM 40 MG ONCE DAILY AT 2PM FOR 7 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD



55841

ARH1.0001231214

<b>Name</b>	Mr. KARUNAKAR POTHARAM		
<b>Patient Identifier</b>	ARHIP55841	<b>Age</b>	68Yr 0Mth 0Days
<b>Sex</b>	Male	<b>Date of Admission</b>	23-May-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	3-7-792, BANK COLONY,VAVILALAPALLY,Karimnagar,Telangana	<b>Ward/ Bed No</b>	Ground Floor, Emergency Ward, Bed no:EME4
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE WITH UNSTABLE ANGINA WITH ECG CHANGES, MILD MR, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-50%  
VENTRICULAR BIGEMINY  
R/F: T2DM, HTN  
CORONARY ANGIOGRAM DONE ON 23/05/2022 - CAD-TVD [LAD, LCX, RCA]

ADV: CABG WITH GRAFT TO LAD, OM, DISTAL RCA

C/o Retrosternal chest pain, radiating to back since 10 days

At Admission

Afebrile

PR: 82/min

BP: 160/90 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-98%

A 68 years old male patient Mr. KARUNAKAR POTHARAM came with c/o Retrosternal chest pain, radiating to back since 10 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE WITH UNSTABLE ANGINA WITH ECG CHANGES, MILD MR, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-50%  
R/F: T2DM, HTN , VENTRICULAR BIGEMINY, CORONARY ANGIOGRAM DONE ON 23/05/2022 – CAD-TVD [LAD, LCX, RCA], ADV: CABG WITH GRAFT TO LAD, OM, DISTAL RCA. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

1. CAP. CLOPITAB-A 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. TONACT 20 MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. TELDAY-H 80MG ONCE DAILY AT 8AM TO CONTINUE.
4. TAB. DILNIP 10 MG ONCE DAILY AT 8PM TO CONTINUE.
5. CAP. METOLAR XR 25 MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. DIAMICRON XR 60 MG **TWICE IN A DAY AT 8 AM AND AT 8 PM** TO CONTINUE.
7. TAB. TAB VOBOSE M 0.3 MG **TWICE IN A DAY AT 8 AM AND AT 8 PM** TO CONTINUE.

REVIEW AFTER 7 DAYS IN CARDIAC OPD

ARH1.0001231028

**Name**

Mrs. MALLESWARI J

**Patient Identifier**

ARHIP55770

**Age**

55Yr  
10Mth  
23Days

**Sex**

Female

**Date of Admission**

17-May-2022

**Date of Discharge  
MLC No**

**Address**

KATTARAMPUR D.NO 8-1-347  
KMR,Karimnagar,Telangana

**Ward/  
Bed No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:103  
B

**Primary Consultant**

DR. SANJAY KUMAR KAMINWAR

## GUILLAIN-BARRE SYNDROME

Patient presented with weakness of bilateral upper and lower limbs (LL>UL)

Trunkal weakness , unable to roll on the bed

Not able to stand from squatting position

AT ADMISSION:

O/E : Quadriplegia,

Bilateral deep tendon reflexes absent

PR: 76/min

BP: 140/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 55 years old female patient Mrs. MALLESWARI J came with c/o weakness of bilateral upper and lower limbs (LL>UL), Trunkal weakness , unable to roll on the bed, Not able to stand from squatting position, nerve conduction studies were done which showed reduced Bilateral median and ulnar compound action potential and prolonged F wave latencies in Bilateral median, ulnar and Tibial nerves, diagnosed as a case of Guillain-Barré syndrome. Intravenous methylprednisolone was given along with other

supportive measures and physiotherapy. Patient improved symptomatically, hence now patient is being discharged in a hemodynamically stable condition with all the required medications and advice.

DISCHARGE MEDICATION:

-----

- 1) TAB. GABANTIP 300 /10 MG ONCE DAILY AT 8PM FOR 10 DAYS
- 2) CAP. REJUNEX CD3 ONCE DAILY AT 8AM FOR 10 DAYS

REVIEW AFTER 7 DAYS IN DR SANJAY KUMAR SIR OPD

APJ1.0016075026

		<b>Name</b>		Mr. SYED SABIR PASHA	
<b>Patient Identifier</b>		ARHIP55764		<b>Age</b>	63Yr 11Mth 7Days
<b>Sex</b>		Male		<b>Date of Admission</b>	17-May-2022
<b>Date of Discharge MLC No</b>					
<b>Address</b>		Q NO B-5/209, PTS NTPC,JYOTHI NAGAR, SOMANAPALLE,,Ramagundam,Telangana		<b>Ward/ Bed No</b>	Second Floor, Semi Private , Bed no:116A
<b>Primary Consultant</b>		Dr. RAMCHANDER TORREM			

CKD STAGE-5

IJV SEPSIS

CVA-INFARCT

DM/HTN/CAD

C/o SOB, vertigo, swelling of feet since 1 day

AT ADMISSION:

Afebrile

PR: 102/min

BP: 130/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

b/l pedal edema

A 63 years old male patient Mr. SYED SABIR PASHA came with c/o SOB, vertigo, swelling of feet since 1 day. All necessary investigations were done and diagnosed as CKD STAGE-5, IJV SEPSIS, CVA-INFARCT, DM/HTN/CAD. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. MHD (2/7)
2. TAB. SOBINIX DS ONCE DAILY AT 8AM AND 8PM TO CONTINUE.
3. TAB. ISOLAZINE **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. ROSAGOLD ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. CARDIVAS 6.125 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
6. TAB. VELTAM 0.2 MG ONCE DAILY AT 8PM TO CONTINUE.
7. TAB. NICARDIA RETARD 10 MG ONCE DAILY AT 8AM TO CONTINUE.
8. TAB. NZCOQ10 ONCE DAILY AT 2PM TO CONTINUE.
9. TAB. FEBGET 40 MG ONCE DAILY AT 8AM TO CONTINUE.
10. TAB. ENCORATE 300 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
11. TAB. MULTI-8 ONCE DAILY AT 2PM TO CONTINUE.
12. TAB. DYTOR 20 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
13. TAB. GEROZ-LP THRICE DAILY AT 8AM 2PM 8PM TO CONTINUE.

REVIEW AFTER 5 DAYS IN NEPHROLOGY OPD

ARH1.0001230729

**Name**

Mr. DULAM MOGILI

**Patient Identifier**

ARHIP55657

**Age**

64Yr  
5Mth  
24Days

**Sex**

Male

**Date of Admission**

09-May-2022

**Date of Discharge  
MLC No**

**Address**

Q.NO SB 150,RK 6  
COLONY,SRIRAMPUR,MANCHERIAL-  
9949312780,Telangana

**Ward/  
Bed No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:106  
B

**Primary Consultant**

DR. NIKHIL GOLI --NEUROLOGY

RECURRENT CVA  
DYSLIPIDAEMIA  
HYPERTENSION  
DEPRESSION

C/o slurring of speech since 1 day weakness of left upper limb and lower limb since 1 day  
History of old CVA 1 year ago  
Known case of hypertension since 10 years on treatment

#### PHYSICAL EXAMINATION:

#### ON ADMISSION

-----

Pt c/c/c

afebrile

PR-72/min

BP-130/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-100%

A 64 yr old male patient Mr. DULAM MOGILI came with c/o slurring of speech since 1 day weakness of left upper limb and lower limb since 1 day, history of old CVA 1 year ago. Known case of hypertension since 10 years on treatment. All necessary investigations done and diagnosed as RECURRENT CVA, DYSLIPIDAEMIA , HYPERTENSION , DEPRESSION. Managed conservatively. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ECOSPRIN 150 MG ONCE DAILY AT 2 PM TO CONTINUE
2. TAB: ATORVAS 40 MG ONCE DAILY AT 8 PM TO CONTINUE
3. TAB: CLOPITAB 75 MG ONCE DAILY AT 2 PM TO CONTINUE
4. TAB. NICARDIA RETARD 20 MG ONCE IN A DAY AT 8 AM TO CONTINUE

Review after 7 days in DR NIKHIL GOLI SIR OPD.



ARH1.0001222607

**Name**

Mrs. G LAXMI

**Patient Identifier**

ARHIP55759

**Age**

73Yr  
9Mth  
12Days

**Sex**

Female

**Date of Admission**

17-May-2022

**Date of Discharge  
MLC No**

**Address**

4-100/31 VENKATESHWARACOLONY

KARIMNAGAR

BILATERAL CEREBELLAR INFARCT  
TYPE II DIABETIC MELLITUS  
HYPERTENSION

C/o slurring of speech , giddiness and generalised weakness since 1 day

#### PHYSICAL EXAMINATION:

##### ON ADMISSION

-----

Pt c/c/c

afebrile

PR-97/min

BP-130/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-99%

A 73 yr old female patient <sup>Mrs. G LAXMI</sup> came with c/o slurring of speech , giddiness and generalised weakness since 1 day. All necessary investigations done and diagnosed as BILATERAL CEREBELLAR INFARCT, TYPE II DIABETIC MELLITUS, HYPERTENSION. Managed conservatively. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ECOSPRIN 150 MG ONCE DAILY AT 2 PM TO CONTINUE
2. TAB: ATORVAS 40 MG ONCE DAILY AT 8 PM TO CONTINUE
3. TAB: ZORYL-M2 **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE

Review after 10 days in DR NIKHIL GOLI SIR OPD.

ARH1.0001231086

**Name**

Mr. SRINIVAS KOTA

**Patient Identifier**

ARHIP55797

**Age**

44Yr  
0Mth  
4Days

**Sex**

Male

**Date of Admission**

19-May-2022

**Date of Discharge  
MLC No**

**Address**

VIDYARANYAPURI, ROAD  
NO:1,Karimnagar,Telangana

**Ward/  
Bed No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:108  
A

**Primary Consultant**

DR. NIKHIL GOLI --NEUROLOGY

ACUTE LEFT MCA INFARCT

C/o weakness of right upper limb and lower limb, giddiness since 1 day

PHYSICAL EXAMINATION:

ON ADMISSION

-----

Pt c/c/c

afebrile

PR-82/min

BP-130/80mmhg

RR-21/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 44 yr old male patient Mr. SRINIVAS KOTA came with c/o weakness of right upper limb and lower limb, giddiness since 1 day. All necessary investigations done and diagnosed as ACUTE LEFT MCA INFARCT. Managed conservatively. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ECOSPRIN 150 MG ONCE DAILY AT 2 PM TO CONTINUE
2. TAB: CLOPITAB 75 MG ONCE DAILY AT 2 PM TO CONTINUE
3. TAB: STORVAS 40 MG ONCE DAILY AT 8 PM TO CONTINUE
4. TAB: TRYCIT ONCE DAILY AT 8 AM TO CONTINUE

Review after 10 days in DR NIKHIL GOLI SIR OPD.

ARH1.0001213822

**Name**

Mr. RAVINDER G

**Patient Identifier**

ARHIP55825

**Age**

52Yr  
11Mth  
11Days

**Sex**

Male

**Date of Admission**

21-May-2022

**Date of Discharge  
MLC No**

**Address**

PRIME HOSPITAL 1 ST FLOR,  
SHARMANAGAR,Karimnagar,Telangana

**Ward/  
Bed No**

First  
Floor,  
CICU ,  
Bed  
no:CICU  
3

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, UNSTABLE ANGINA

MODERATE LV SYSTOLIC DYSFUNCTION [EF-37%]

OLD CAD, AWTMI, POST PTCA DES TO LAD/OM DONE ON 05/06/21

R/F : HTN, T2DM

C/o chest pain burning type since 1 day associated with shortness of breath on exertion  
History of bilateral pedal oedema +

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 74/min

BP: 120/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 52 years old male patient <sup>RAVINDER</sup> came with c/o chest pain burning type since 1 day associated with shortness of breath on exertion, bilateral pedal oedema +. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, MODERATE LV SYSTOLIC DYSFUNCTION [EF-37%], OLD CAD, AWTMI, POST PTCA DES TO LAD/OM DONE ON 05/06/21 . Managed conservatively. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. PRASITA 10MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. STORVAS 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB: TELMA 20MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. GLUCOMET GP 1/850 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0001231015

<b>Name</b>	Mr. RAJIAH VODNALA		
<b>Patient Identifier</b>	ARHIP55761	<b>Age</b>	72Yr 0Mth 6Days
<b>Sex</b>	Male	<b>Date of Admission</b>	17- May- 2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	WALLAMPAHAD,Karimnagar,Telangana	<b>Ward/ Bed No</b>	Second Floor, Male General Ward, Bed no:GW 22
<b>Primary Consultant</b>	Dr. SURESH GOUD S(MS,M.Ch		

BENIGN PROSTATIC HYPERTROPHY  
SURGERY: TRANSURETHRAL RESECTION OF THE PROSTATE DONE ON 19/05/2022

C/o difficulty in passing urine since 1 week

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 60/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 97%

P/A: Soft

All required investigations done and enclosed

A 72 yrs old male patient Mr. RAJIAH VODNALA came to the hospital with c/o difficulty in passing urine since 1 week. All necessary investigations done and diagnosed as BENIGN PROSTATIC HYPERTROPHY, SURGERY: TRANSURETHRAL RESECTION OF THE PROSTATE DONE ON 19/05/2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB: ROXSAFE CV 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: FAMOCID 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: NDQ10 ONCE DAILY AT 2PM FOR 10 DAYS
5. SYP: CREMAFFIN 15 ml ONCE DAILY AT 8PM

REVIEW AFTER 11 DAYS TO UROLOGY OPD



ARH1.0001231078

**Name**

Mrs.  
SAYILLA  
LAXMI

**Patient Identifier**

ARHIP55792

**Age**

49Yr  
0Mth  
4Days

**Sex**

Female

**Date of  
Admission**

19-  
May-  
2022

**Date of Discharge  
MLC No**

**Address**

H.NO:10-  
25,CHEEMALAPET,JULAPALLY,PEDDAPALLY,Other,Telanga  
na

**Ward/  
Bed No**

Second  
Floor,  
Female  
Genera  
l Ward,  
Bed  
no:GW  
1

**Primary Consultant**

Dr. SURESH GOUD S(MS,

LEFT URETERIC CALCULUS

SURGERY: LEFT URSL + DJ STENTING ON 20/05/2022

C/o abdominal pain, radiating to back a/w vomiting since 1 week.

ON ADMISSION

-----

Patient c/c

Afebrile

PR-92/min

BP-110/70mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft

SPO2-99%

A 49 years old female patient Mrs. SAYILLA LAXMI presented to hospital with c/o abdominal pain, radiating to back a/w vomiting since 1 week. All necessary investigations were done and diagnosed as LEFT URETERIC CALCULUS, SURGERY: LEFT URSL + DJ STENTING ON 20/05/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB: ROXSAFE CV 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: FAMOCID 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: NDQ10 ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO UROLOGY OPD.

REVIEW AFTER 3 WEEKS FOR DJ STENT REMOVAL.

ARH1.0001077815

**Name**

Mr. RAJIAH  
RADHARAPU

**Patient Identifier**

ARHIP55818

**Age**

64Yr  
2Mth  
0Days

**Sex**

Male

**Date of Admission** 21-May-2022

**Date of Discharge**

**MLC No**

**Address**

THIRUMALNAGAR,Karimnagar,Telangana

**Ward/Bed No**

Second  
Floor,  
Semi  
Private,  
Bed  
no:122  
A

**Primary Consultant**

DR. NIKHIL GOLI --NEUROLOGY

LUMBAR SPONDYLOSIS  
SUPRASPINATUS TENDINOPATHY  
REFRACTORY PAIN

C/o chronic refractory backache

PHYSICAL EXAMINATION:

ON ADMISSION

-----

Pt c/c/c

afebrile

PR-82/min

BP-130/80mmhg

RR-21/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 64 yr old male patient Mr. RAJAJIAH RADHARAPU came with c/o chronic refractory backache. All necessary investigations done and diagnosed as LUMBAR SPONDYLOSIS, SUPRASPINATUS TENDINOPATHY, REFRACTORY PAIN. Managed conservatively. Orthopaedic and Neurosurgeon consultations taken and advised followed. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: GABAPIN-NT 400/10 ONCE DAILY AT 8 PM TO CONTINUE
2. TAB: NEURIT CD3 ONCE DAILY AT 8 AM TO CONTINUE

Review after 10 days in DR NIKHIL GOLI SIR OPD.

ARH1.0001231207

**Name**

Mrs. SALMA  
SULTANA

**Patient Identifier** ARHIP55840

**Age** 58Yr  
11Mth  
8Days

**Sex** Female

**Date of Admission** 23-May-2022

**Date of Discharge**  
**MLC No**

**Address** 3-4-114 SAWARAN  
STREE,Karimnagar,Telanga  
na

**Ward/ Bed No** First Floor,  
RECOVERY  
ROOM, Bed  
no:RR 10

**Primary Consultant** DR. SRI KARAN UDDESH --  
INTERNAL

### SMALL BOWEL OBSTRUCTION

C/o multiple episodes of vomitings, gastric region pain, body pains, mild vertigo and fever with chills since 1 day

#### AT ADMISSION:

PR: 97/min

BP: 150/90 mmHg

RS: BAE+

CVS: S1S2

RR: 21/min

SPO2: 97%

P/A: Soft

A 58 years old female patient Mrs. SALMA SULTANA came with above mentioned complaints. Patient diagnosed as SMALL BOWEL OBSTRUCTION. Managed conservatively. General surgeon consultation taken and advice followed. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA.

#### DISCHARGE MEDICATION:

-----

1) TAB. TAXIM-O 200 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS

2) TAB. METROGYL 400 MG THRICE DAILY AT 8AM, 2PM AND 8PM FOR 5 DAYS

3) TAB. BUSCOPAN TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

4) SYP. SUCRAFIL-O 2tsp TWICE DAILY AT 8AM AND 8PM

5) TAB. SOMPRAZ-L TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

ADVISED TO CONSULT GENERAL SURGEON DR. GOUTHAM ROY

55736

ARH1.0001230851		<b>Name</b>	Mrs. LAXMI BHOND
<b>Patient Identifier</b>	ARHIP55736	<b>Age</b>	46Yr 0Mth 12Days
<b>Sex</b>	Female	<b>Date of Admission</b>	16-May-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	KORUTLA,JAGTIAL,Other,Telangana	<b>Ward/Bed No</b>	First Floor, CT POST, Bed no:CT 2
<b>Primary Consultant</b>	Dr SOMASHEKAR K(MS		

Ss

CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + LV DYSFUNCTION + DM+HTN+S/P IWMI+OBESITY

SURGERY -CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG TO OM,PDA] DONE ON 15/05/2022.

C/o chest pain, shortness of breath on exertion since 3 days

AT ADMISSION:

Pt c/c

Afebrile

PR: 88/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 46 years old female patient Mrs. LAXMI BHOND came with c/o chest pain, shortness of breath on exertion since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + LV DYSFUNCTION + DM+HTN+S/P IWMI+OBESITY, SURGERY -CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG TO OM,PDA] DONE ON 15/05/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, PARADOXICAL SEPTAL MOTION, MODERATE LV SYSTOLIC FUNCTION, GRADE-I DIASTOLIC DYSFUNCTION. NO PE/CLOT/VEG, EF-38%

BMI is 20.6 kg/m<sup>2</sup>.

Sr. Creatinine report on 16/05/2022 1.0 mg/dl.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. ND VIT ONCE DAILY AT 2PM TO CONTINUE.
- 4) TAB. ROSAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. ALPRAX 0.25 MG ONCE DAILY AT 9AM FOR 5 DAYS.
- 6) TAB. MET XL 50 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 7) TAB. METFORMIN 500 MG ONCE DAILY AT 8AM TO CONTINUE.
- 8) TAB. CALPOL 500 MG THRICE DAILY AT 8AM 2PM AND 8PM FOR 5 DAYS.
- 9) TAB. ROXSAFE CV 125+100 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.
- 10) TAB. DOXY **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS.
- 11) TAB. FAMOCID 40 MG ONCE DAILY AT 7AM BBF FOR 5 DAYS.
- 12) TAB. ALPRAX 0.25 MG ONCE DAILY AT 7 PM FOR 5 DAYS.



REVIEW AFTER 11 DAYS TO CTVS OPD WITH FBS, PLBS REPORTS

Lingia

ARH1.0001231202

**Name**

Mr.  
LINGAIAH  
CHILUMULA

**Patient Identifier**

ARHIP55839

**Age**

56Yr 0Mth  
2Days

**Sex**

Male

**Date of  
Admission**

22-May-  
2022

**Date of Discharge  
MLC No**

**Address**

15-3-653/1,  
LBNAGAR,PEDDAPALLI,Telangana

**Ward/Bed  
No**

First  
Floor,  
CICU ,  
Bed  
no:CICU1  
2

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE , UNSTABLE ANGINA, SR

SEVERE LV SYSTOLIC DYSFUNCTION, [EF-30%]

POST PTCA DONE ON 2009 [LAD & RCA]

CORONARY ANGIOGRAM DONE ON 24/05/2022 - CAD-TVD [LAD, LCX, RCA]

PLAN CABG.

R/F DM, ALCOHOL, TOBACCO

C/o chest pain since a/w SOB since 10 days

At Admission

Afebrile

PR: 92/min

BP: 90/50 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-98%

A 56 years old male patient Mr. LINGAIAH CHILUMULA came with c/o chest pain since a/w SOB since 10 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , UNSTABLE ANGINA, SR, SEVERE LV SYSTOLIC DYSFUNCTION, [EF-30%], POST PTCA DONE ON 2009 [LAD & RCA], CORONARY ANGIOGRAM DONE ON 24/05/2022 - CAD-TVD [LAD, LCX, RCA], PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. GLYCOMET-M 40MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0001231258

<b>Name</b>	Mr. MD BABAR SHAREEF		
<b>Patient Identifier</b>	ARHIP55859	<b>Age</b>	55Yr 0Mth 0Days
<b>Sex</b>	Male	<b>Date of Admission</b>	24-May-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	korutla,jagityal,Karimnagar,Telangana	<b>Ward/ Bed No</b>	Ground Floor, Emergency Ward, Bed no:EME 8
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY		

BREATHLESSNESS EVALUATION  
GLOBAL HYPOKINESIA, MILD MR, MILD PAH, SR,  
MODERATE LV SYSTOLIC DYSFUNCTION [EF- 35%]  
R/F: HTN, SMOKING,  
CKD  
CORONARY ANGIOGRAM DONE ON 24.05.2022 -NORMAL CORONARIES [LEFT DOMINANT SYSTEM]  
PLAN MEDICAL MANAGEMENT

C/o Shortness of breath on exertion, sweatings and dry cough since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 90/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 55 years old male patient Mr. MD BABAR SHAREEF came with c/o Shortness of breath on exertion, sweatings and dry cough since 1 day. All necessary investigations were done and diagnosed as BREATHLESSNESS EVALUATION, GLOBAL HYPOKINESIA, MILD MR, MILD PAH, SR, MODERATE LV SYSTOLIC DYSFUNCTION [EF- 35%], R/F: HTN, SMOKING, CKD, CORONARY ANGIOGRAM DONE ON 24.05.2022 -NORMAL CORONARIES [LEFT DOMINANT SYSTEM], PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

#### DISCHARGE MEDICATION:

-----

1. TAB. AZTOLET 10MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CARDIVAS 3.125 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. ISOLAZINE **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. DYTOR PLUS 10MG ONCE DAILY AT 8PM TO CONTINUE.
5. TAB. MICINAC 600 MG WITH CUP OF WATER **TWICE IN A DAY AT 8 AM 8 PM** FOR 3 DAYS

NEPHROLOGIST TREATMENT TO CONTINUE

REVIEW AFTER 10 DAYS TO CARDIAC OPD

ARH1.0001231196

<b>Name</b>	Mr. NARAHARI CHOUTAPELLY		
<b>Patient Identifier</b>	ARHIP55835	<b>Age</b>	64Yr 0Mth 4Days
<b>Sex</b>	Male	<b>Date of Admission</b>	22-May-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	1-34, BALAPALLY,JAGTIAL,Telangana	<b>Ward/ Bed No</b>	First Floor, CICU , Bed no:CICU 1
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%

CORONARY ANGIOGRAM DONE ON 22/05/2022 - CAD-DVD (LAD, RCA)

PRIMARY PTCA+DES TO LAD (Two stents) WITH 3.5 X 29 MM METAFOR TO PROXIMAL LAD, 3.0 X 24 MM METAFOR TO MID LAD DONE ON 22/05/2022

R/F: HTN, T2DM

C/o chest pain since 4-5 days

AT ADMISSION:

Afebrile

PR: 120/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 64 years old male patient Mr. NARAHARI CHOUTAPALLY came with c/o chest pain since 4-5 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWTMI, NO TLT, SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%, CORONARY ANGIOGRAM DONE ON 22/05/2022 - CAD-DVD (LAD, RCA), PRIMARY PTCA+DES TO LAD (Two stents) WITH 3.5 X 29 MM METAFOR TO PROXIMAL LAD, 3.0 X 24 MM METAFOR TO MID LAD DONE ON 22/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. TONACT 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. CILODOC 50MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 5) CAP. ABFLO 100MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 6) TAB. ZORYL M2 FORT 2MG ONCE DAILY AT 8AM TO CONTINUE.
- 7) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.



ARH1.0001231335

		Mr. THIRUPATHI VADLAKONDA	
Patient Identifier	ARHIP55869	Age	48Yr 0Mth 1Days
Sex	Male	Date of Admission	25-May-2022
Date of Discharge MLC No			
Address	H.NO:1-4,BEEERSANI,BUGGARAM,JAGITIAL,Other,Telangana	Ward/Bed No	First Floor, CT POST, Bed no:CT 1
Primary Consultant	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant-Cardio Thoracic & Vascular Surgeon)--C T SURGERY		

55882

ARH1.0001213822	<b>Name</b>	Mr. RAVINDER G
<b>Patient Identifier</b>	ARHIP55882	<b>Age</b> 52Yr 11Mth 14Days
<b>Sex</b>	Male	<b>Date of Admission</b> 26-May-2022
<b>Date of Discharge</b>		
<b>MLC No</b>		
<b>Address</b>	PRIME HOSPITAL 1 ST FLOR, SHARMANAGAR, Karimnagar, Telangana	<b>Ward/ Bed No</b> First Floor, Day Care, Bed no:DC 2
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY	

CORONARY ARTERY DISEASE, NSTEMI  
MODERATE LV SYSTOLIC DYSFUNCTION [EF-37%]  
OLD CAD, AWMI, POST PTCA DES TO LAD/OM DONE ON 12/06/21  
R/F : HTN, T2DM  
CORONARY ANGIOGRAM DONE ON 26/05/2022 -NORMAL CORONARIES  
PLAN MEDICAL MANAGEMENT

C/o chest pain burning type since 1 day associated with shortness of breath on exertion  
History of bilateral pedal oedema +

#### AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 52 years old male patient RAVINDER came with c/o chest pain burning type since 1 day associated with shortness of breath on exertion, bilateral pedal oedema +. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, MODERATE LV SYSTOLIC DYSFUNCTION [EF-37%], OLD CAD, AWTMI, POST PTCA DES TO LAD/OM DONE ON 12/06/21 , R/F : HTN, T2DM, CORONARY ANGIOGRAM DONE ON 26/05/2022 -NORMAL CORONARIES , PLAN MEDICAL MANAGEMENT . Patient is being discharged in hemodynamically stable condition with required medication and advise.

#### DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. PRASITA 10MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. STORVAS 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. PROLOMET -XL 50MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB: TELMA 20MG ONCE DAILY AT 8PM TO CONTINUE.
6. TAB. GLUCOMET GP 1/850 MG ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS.

ARH1.0001230944

**Name**

Mrs. AFZAL  
BEGUM

**Patient  
Identifier**

ARHIP55737

**Sex**

Female

**Expired Date  
MLC No**

17-May-2022

**Address**

kashmeergadda, Karimnagar, Telangana

**Primary  
Consultant  
Surgeons**

DR. SRI KARAN UDDESH --INTERNAL  
MEDICINE

**Age**

75Yr  
0Mth  
1Days

**Date of  
Admission**

16-May-  
2022

**Ward/Bed No**

First  
Floor,  
MICU,  
Bed  
no: MICU  
10

**Consultants**

**Anesthesiologi  
sts**

☐ **Diagnosis**  
S

**Diagnosis**

Disease	Disease Type
SEPTIC SHOCK.	Pd

History of fever, burning micturition since 4 days

Patient brought to ER in gasping state

AT ADMISSION:

Patient not responding to commands  
PR: 97/min

BP: not recordable

RS: crackles +

CVS: S1S2

RR: 40/min

SPO2: 95%

P/A: Soft,

A 75 years old female patient Mrs. AFZAL BEGUM presented to hospital with above-mentioned complaints. Patient had VT , 150 J DC shock given, reverted to sinus rhythm, treated with inj. Amiodarone. Patient was intubated to mechanical ventilator support on SIMV mode. CPR was initiated as per ACLS protocols, in spite of best effort return of spontaneous circulation could not be obtained, hence patient was declared as dead at 12.37am on 17/05/2022.

#### CAUSE OF DEATH

-----

CARDIOPULMONARY ARREST SECONDARY TO SEPTIC SHOCK SYNDROME.

55866

ARH1.0001231300

<b>Name</b>	Mrs. K BHUMAKKA
<b>Patient Identifier</b>	ARHIP55866
<b>Age</b>	65Yr 0Mth 2Days
<b>Sex</b>	Female
<b>Date of Admission</b>	24-May-2022
<b>Date of Discharge</b>	
<b>MLC No</b>	
<b>Address</b>	DULLUR KORUTLA,Karimnagar,Telangana
<b>Ward/Bed No</b>	First Floor, CICU , Bed no:CICU 3
<b>Primary Consultant Surgeons</b>	Dr. Vidya Sagar A--CARDIOLOGY
<b>Consultants</b>	

ACUTE DECOMPENSATED HEART FAILURE

DCMP, LBBB, SEVERE MR, MILD PAH, SR

SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%  
DENOVO T2DM, HTN

## C/o shortness of breath on exertion since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 98/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 22/min

SPO2: 92%

P/A: Soft

A 65 years old female patient Mrs. K BHUMAKKA came with c/o **shortness of breath on exertion since 1 day**. All necessary investigations were done and diagnosed as ACUTE DECOMPENSATED HEART FAILURE, DCMP, LBBB, SEVERE MR, MILD PAH, SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%, DENOVO T2DM, HTN. Managed conservatively. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. TONACT 10MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. ALDACTONE 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. VELOZ 20 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001227343

**Name**

Mr. RAJAMALLU T

**Patient Identifier**

ARHIP55843

**Age**

68Yr  
3Mth  
25Days

**Sex**

Male

**Date of Admission**

23-May-2022

**Date of Discharge  
MLC No**

**Address**

SULTHANABAD,Karimnagar,Telangana

**Ward/  
Bed No**

First  
Floor,  
MICU,  
Bed  
no:MIC  
U 1

**Primary Consultant**

DR. NIKHIL GOLI --NEUROLOGY

## UNCONTROLLED TYPE II DIABETES MELLITUS HYPOKALAEMIA

H/o Drowsiness since 1 day

H/o fever and weakness of left upper limb and lower limb

Known case of diabetes mellitus, CVA subacute SDH

### AT ADMISSION:

Afebrile

PR: 76/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 97%

P/A: Soft, BS+



A 68 years old male patient Mr. RAJAMALLU T came with c/o drowsiness since 1 day, h/o fever and weakness of left upper limb and lower limb. All necessary investigations were done and diagnosed as UNCONTROLLED TYPE II DIABETES MELLITUS, HYPOKALAEMIA. Managed conservatively. General Physician consultation taken and advise followed. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

- 1) TAB. LEVERA 500 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 2) CAP. NEURIT CD3 ONCE DAILY AT 2PM FOR 7 DAYS
- 3) INJ HUMAN MIXTARD 30/70 12 Units AT 8AM 8 Units AT 8PM CONTINUE
- 4) SYP. DUPHALAC 15 ml ONCE DAILY AT 8PM

REVIEW AFTER 7 DAYS IN DR NIKHIL SIR OPD

Pochamma 55864

## CORROSIVE POISONING

Patient alleged to consume sanifresh (harpic) of approximately 50 mL quantity at her residence  
C/o Severe abdominal pain, throat pain

AT ADMISSION:

Patient c/c

PR: 113/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 24/min

SPO2: 98%

P/A: Soft, BS+

A 30 years old female patient POCHAMMA came with h/o alleged to consume sanifresh (harpic) of approximately 50 mL quantity at her residence, c/o Severe abdominal pain, throat pain. All necessary investigations were done and diagnosed as CORROSIVE POISONING. Managed conservatively. Patient is referred to Higher Centre for Surgical Gastroenterologist for further management. Hence, patient is discharged at request.

ARH1.0001230872

**Name**

Mr. MYDAM  
VENKANNA

**Patient Identifier**

ARHIP55717

**Age**

62Yr  
0Mth  
14Days

**Sex**

Male

**Date of  
Admission**

13-May-  
2022

**Date of Discharge  
MLC No**

**Address**

Jyothinagar Naspur,Mancherial,Telangana

**Ward/  
Bed No**

First  
Floor,  
MICU,  
Bed  
no:MIC  
U 12

**Primary Consultant**

DR. SRI KARAN UDDESH

## INTRACEREBRAL HAEMORRHAGE AKI [PROBABLE CORTICAL NECROSIS] RHABDOMYOLYSIS

C/o SOB grade-2 since 3 days, b/l pedal edema, decreased urine output

History of sudden onset proximal muscle weakness of lower limbs  
Was admitted at an outside hospital and was referred here in view of increased dyspnoea and creatine

### Chronic alcoholic

AT ADMISSION:

Afebrile

PR: 78/min

BP: 150/100mmHg

RS: BAE+

CVS: S1S2

CNS-B/I proximal muscle weakness of lower limbs, power 1/5

RR: 30/min

SPO2: 96% on room air

P/A: Soft,

A 62 years old male VENKANNA patient presented with the above-mentioned complaints as patient had bilateral lower limb weakness at admission an MRI of the spine was done which was normal. CPK was sent which was very high, in view of anuric AKI and CPK being high with proximal muscle weakness a diagnosis of rhabdomyolysis was made. Patient was started on haemodialysis on as needed basis. Patient was started on other supportive measures. During the hospital stay in the ICU patient suddenly developed right sided upper limb and lower limb weakness along with slurring of speech a CT brain revealed intracerebral haemorrhage. Neurosurgery and Neurophysician consultation was taken and patient was managed conservatively. Totally patient underwent 14 cycles of haemodialysis but patient still continued to have anuric AKI, so Nephrologist is suspecting probable cortical necrosis and renal biopsy was planned but as the patient is not stable to undergo renal biopsy procedure it has been deferred for now. Now the patient is being discharged in haemodynamically stable condition and will be requiring HEPARIN free dialysis thrice a week. He is being discharged with the following medication advice.

DISCHARGE MEDICATION:

-----

- 1) TAB. NODOSIS 500 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 2) TAB. ENCORODE 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 3) TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 7 DAYS
- 4) TAB. RENOSAVE TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

- 5) TAB. KETO CHECK THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS
- 6) TAB. CUDCE FORT THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS
- 7) TAB. DEPIN RETARD 20 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 8) SYP. GLYCEROL 2tsp THRICE IN A DAY AT 8 AM 2 PM 8 PM
- 9) SYP. DUPHALOC 10 ML THRICE IN A DAY AT 8 AM 2 PM 8 PM

REVIEW AFTER 5 DAYS IN NEPHROLOGY OPD

55890

RTA POLYTRAUMA  
MULTIPLE SMALL HAEMORRHAGIC CONTUSIONS  
TRAUMATIC SAH  
DIFFUSE AXONAL INJURY GRADE-I  
FRACTURE RIGHT HUMERUS

Alleged to have sustained injury due to RTA Rolling of Car over the road on 26/05/22 around 3.30 pm sustained injury to right arm

Known case of hypothyroidism

AT ADMISSION:

Patient drowsy

Febrile -100 F

PR: 83/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft, BS+

GCS- E2,V3,M5, B/I PERL

A 59 years old female patient LAXMI REDDY came with Alleged to have sustained injury due to RTA Rolling of Car over the road on 26/05/22 around 3.30 pm sustained injury to right arm. All necessary investigations were done and diagnosed as RTA POLYTRAUMA, MULTIPLE SMALL HAEMORRHAGIC CONTUSIONS, TRAUMATIC SAH, DIFFUSE AXONAL INJURY GRADE-I, FRACTURE RIGHT HUMERUS. Patient was hypotensive, ionotropic support given and now patient is haemodynamically stable. Patient's Hb was 7.7 mg/dl and 1 unit PRBC transfusion given. Patient's condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA.

Nagireddy tkr vr

Rajaiah dhs vr



ARH1.0001231422

**Name**

Mr. AKULA  
MOGILAI AH

**Patient  
Identifier**

ARHIP55895

**Age**

65Yr  
0Mth  
0Days

**Sex**

Male

**Date of  
Admission**

27-  
May-  
2022

**Date of  
Discharge  
MLC No**

**Address**

PARKAL, Parkal, Telangana

**Ward/  
Bed No**

First  
Floor,  
Day  
Care,  
Bed  
no: D  
C 1

**Primary  
Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

#### PERIOPERATIVE RISK EVALUATION

RWMA + MILD MR, SR

MILD LV SYSTOLIC DYSFUNCTION, (EF-50%)

CORONARY ANGIOGRAM DONE ON 27/05/2022- CAD- SVD LAD (D)

ADVISED MEDICAL MANAGEMENT (DIAGONAL THIN VESSEL)

PATIENT CAN UNDERGO NON-CARDIAC SURGERY UNDER MILD RISK

Patient came for preoperative risk evaluation for hernioplasty surgery

#### AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 65 years old male patient Mr. AKULA MOGILAI AH came for preoperative risk evaluation for hernioplasty surgery. All necessary investigations were done and diagnosed as PERIOPERATIVE RISK EVALUATION RWMA + MILD MR, SR, MILD LV SYSTOLIC DYSFUNCTION, (EF-50%), CORONARY ANGIOGRAM DONE ON 27/05/2022- CAD- SVD LAD (D), ADVISED MEDICAL MANAGEMENT (DIAGONAL THIN VESSEL), PATIENT CAN UNDERGO NON-CARDIAC SURGERY UNDER MILD RISK. Patient is being discharged in hemodynamically stable condition with required medication and advise.

#### DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. TONACT 20MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. NIKORAN 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001231140

Name		Mr. PUNNA BALAIAH	
<b>Patient Identifier</b>	ARHIP55816	<b>Age</b>	58Yr 0Mth 1Days
<b>Sex</b>	Male	<b>Date of Admission</b>	20-May-2022
<b>Expired Date</b>	21-May-2022		
<b>MLC No</b>			
<b>Address</b>	H.NO:9-2-207,BHAGATH NAGAR,Telangana	<b>Ward/Bed No</b>	First Floor, RECOVERY ROOM, Bed no:RR 7
<b>Primary Consultant</b>	DR. SUBRAT KUMAR SOREN -- NEUROSURGERY	<b>Consultants</b>	
<b>Surgeons</b>	DR. SUBRAT KUMAR SOREN -- NEUROSURGERY	<b>Anesthesiologists</b>	Dr. K.S.D.KRISHNA KIRAN-- ANAESTHESIOLOGY



Cause of Death

Cause of Death

Diagnosis

Diagnosis

Disease	Disease Type
ROAD TRAFFIC ACCIDENT. LEFT FRONTO TEMPORO PARIETAL ACUTE SUBDURAL HAEMORRHAGE WITH MIDLINE SHIFT	

Alleged to have sustained injury due to slip and fall from two wheeler himself on 20/05/22  
H/o LOC, ENT bleeding+

AT ADMISSION:

Patient unresponsive

PR: 124/min

BP: 170/100mmHg

RS: BAE+

CVS: S1S2

RR: 21/min

SPO2: 97%

P/A: Soft

A 58 yrs old male patient MR. PUNNA BALAIAH came to hospital with alleged to have sustained injury due to slip and fall from two wheeler himself on 20/05/22, h/o LOC, ENT bleeding+. All necessary investigations done and diagnosed as ROAD TRAFFIC ACCIDENT. LEFT FRONTO TEMPORO PARIETAL ACUTE SUBDURAL HAEMORRHAGE WITH MIDLINE SHIFT, SURGERY: LEFT FRONTO TEMPORO PARIETAL DECOMPRESSIVE CRANIECTOMY AND ACUTE SDH EVACUATION done on 21/05/2022. Post decompression surgery, patient was on ventilator (VC/AC mode) in view of low GCS. Poor prognosis explained to patient attendants. On 21.05.2022 patient had sudden cardiac arrest. CPR started according to ACLS guidelines Inj.Adrenaline given every 3 minutes. Patient not responded to given treatment. CPR continued. Multiple doses of inj. Adrenaline given. Patient not reverted to normal sinus rhythm. Pupils dilated and fixed, Carotid

pulse not felt. 12 lead ECG showed asystole, hence declared dead at 4.50 AM on 21/05/2022.

CAUSE OF DEATH: CARDIO PULMONARY AREEST SECONDARY TO FRONTO PARIETAL ACUTE MASSIVE SUBDURAL HAEMORRHAGE

ARH1.0001231442		<b>Name</b>	Mrs. SARASWATHAMMA V
<b>Patient Identifier</b>	ARHIP55900	<b>Age</b>	80Yr 0Mth 1Days
<b>Sex</b>	Female	<b>Date of Admission</b>	27-May-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	BALAJINAGAR,Karimnagar,Telangana	<b>Ward/Bed No</b>	First Floor, SICU, Bed no:SICU 6
<b>Primary Consultant</b>	DR. SUBRAT KUMAR SOREN -- NEUROSURGERY		

## CLOSED HEAD INJURY

Alleged history of sustained injury due to slip and fall on 27/05/2022 around 5.30 pm at her home

History of 2 episodes vomitings +

Known case of hypertension on medication

AT ADMISSION:

Patient is drowsy

PR: 74/min

BP: 150/110mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 97%

P/A: Soft, BS+

GCS -E3, V4, M6

A 80yr old female patient <sup>Mrs. SARASWATHAMMA</sup> came to hospital with alleged history of sustained injury due to slip and fall on 27/05/2022 around 5.30 pm at her home, h/o 2 episodes vomitings +. All necessary investigations done and diagnosed as CLOSED HEAD INJURY . Conservative medical management given. Patient is being discharged in a hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB: AUGMENTIN 625 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB. DOLO 650 TWICE DAILY AT 8AM, 8PM FOR 5DAYS.
3. TAB. LEVIPIL 500 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS.
4. TAB: PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 7 DAYS.
5. TAB. NAXDOM **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS.

Continue old hypertensive medications

REVIEW AFTER 7 DAYS IN NEUROSURGERY OPD.

ARH1.0001187329		<b>Name</b>	Mr. GUMMADI MALLAIAH
<b>Patient Identifier</b>	ARHIP55870	<b>Age</b>	72Yr 5Mth 24Days
<b>Sex</b>	Male	<b>Date of Admission</b>	25-May-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	1-2-57,shashabmahal,near srinivasa theater,Karimnagar,Telangana	<b>Ward/ Bed No</b>	First Floor, CICU , Bed no:CICU12
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE WMI, SR

NORMAL LV SYSTOLIC FUNCTION, EF-55%

R/F: HTN, T2DM

S/P LEFT PCNL (2007)

CORONARY ANGIOGRAM DONE ON 25/05/2022 – CAD-DVD (RCA, LAD)

PRIMARY PTCA+DES TO RCA, LAD WITH 3.5 X 38 MM XIENCE XPEDITION TO RCA, 3.5 X 28 MM XIENCE XPEDITION TO LAD DONE ON 25/05/2022

C/o chest pain a/w nausea, sweating since 2 days

AT ADMISSION:

Afebrile

PR: 92/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 97%

P/A: Soft

A 72 years old male patient Mr. GUMMADI MALLAIAH came with c/o chest pain a/w nausea, sweating since 2 days . All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, SR, NORMAL LV SYSTOLIC FUNCTION, EF-55%, R/F: HTN, T2DM, S/P LEFT PCNL (2007), CORONARY ANGIOGRAM DONE ON 25/05/2022 - CAD-DVD (RCA, LAD), PRIMARY PTCA+DES TO RCA, LAD WITH 3.5 X 38 MM XIENCE XPEDITION TO RCA, 3.5 X 28 MM XIENCE XPEDITION TO LAD DONE ON 25/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. AX CER 90MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. TONACT 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. VOBOSE-M 0.3/500 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. VELOZ 20 MG ONCE DAILY AT 8AM BEFORE BREAKFAST TO CONTINUE.
- 6) SYP. CREMAFFIN 10 ml ONCE DAILY AT 8 PM

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.



SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001139752		<b>Name</b>	Mr. VOLLALA RAMESH
<b>Patient Identifier</b>	ARHIP55874	<b>Age</b>	44Yr 11Mth 27Days
<b>Sex</b>	Male	<b>Date of Admission</b>	25-May-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	T2-61, PH COLONY, GODAVARIKHANI, DIST: PEDDAPALLY,,Karimnagar,Telangana	<b>Ward/ Bed No</b>	First Floor, CICU , Bed no:CICU1 1
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

NORMAL LV SYSTOLIC FUNCTION, EF-60%

R/F: HTN, T2DM

CORONARY ANGIOGRAM DONE ON 26/05/2022 - CAD-DVD (LAD & RCA)

PTCA+DES TO LAD WITH 3.0 X 28 MM BIOFREEDOM DONE ON 26/05/2022  
MEDICAL MANAGEMENT FOR RCA

C/o chest pain since few days a/w sweating

AT ADMISSION:

Afebrile

PR: 80/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 44 years old male patient Mr. VOLLALA RAMESH came with c/o chest pain since few days a/w sweating. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWTMI, NO TLT, SR, NORMAL LV SYSTOLIC FUNCTION, EF-60%, R/F: HTN, T2DM, CORONARY ANGIOGRAM DONE ON 26/05/2022 - CAD-DVD (LAD & RCA), PTCA+DES TO LAD WITH 3.0 X 28 MM BIOFREEDOM DONE ON 26/05/2022, MEDICAL MANAGEMENT FOR RCA. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. PAN 40 MG ONCE DAILY AT 8AM FOR 7 DAYS
- 5) TAB. TENIVA-M ONCE DAILY AT 8PM TO CONTINUE.
- 6) TAB. STARPRESS-R XL 25 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001231358

<b>Name</b>	Mr. HARISHANKAR .		
<b>Patient Identifier</b>	ARHIP55879	<b>Age</b>	41Yr 0Mth 2Days
<b>Sex</b>	Male	<b>Date of Admission</b>	26-May-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	1 GOPALPUR,Karimnagar,Telangana	<b>Ward/ Bed No</b>	First Floor, CICU , Bed no:CICU 9
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE INFERIOR WALL MYOCARDIAL INFARCTION, NO TLT, SR

MILD LV SYSTOLIC DYSFUNCTION, EF-45%

R/F: HTN, T2DM

CORONARY ANGIOGRAM DONE ON 26/05/2022 – CAD-SVD (LCX)

PRIMARY PTCA+DES TO LCX WITH 2.5 X 13 MM METAFOR DONE ON 26/05/2022

C/o Retrosternal chest pain since 1 day associated with shortness of breath

AT ADMISSION:

Afebrile

PR:64/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 41 years old male patient Mr. HARISHANKAR came with c/o retrosternal chest pain since 1 day associated with shortness of breath. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE INFERIOR WALL MYOCARDIAL INFARCTION, NO TLT, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-45%, R/F: HTN, T2DM , CORONARY ANGIOGRAM DONE ON 26/05/2022 - CAD-SVD (LCX), PRIMARY PTCA+DES TO LCX WITH 2.5 X 13 MM METAFOR DONE ON 26/05/2022 . Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASITA 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. STORVAS 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001231351

**Patient Identifier** ARHIP55878

**Sex** Male

**Date of Discharge**  
**MLC No**

**Address** BOMMAREDDIPALLI,DHARMARAM,PEDDAPALLI,Other,Telangana

**Primary Consultant** Dr. Vidya Sagar A--CARDIOLOGY

**Name** Mr. YELLA  
REDDY  
SINGIREDDY  
**Age** 42Yr 0Mth  
3Days  
**Date of Admission** 25-May-2022

**Ward/Bed No** First  
Floor,  
CICU ,  
Bed  
no:CICU1  
0

CORONARY ARTERY DISEASE, EVOLVED ANTERIOR WALL MI, NO TLT

NORMAL LV SYSTOLIC FUNCTION, EF-60%

R/F: HTN

CORONARY ANGIOGRAM DONE ON 26/05/2022 - CAD-DVD (RCA, LAD)

PTCA+DES TO LAD, RCA WITH 3.0 X 24 MM METAFOR TO LAD, 2.0 X 10 MM BALLOON TO RCA DONE ON 26/05/2022

C/o chest pain on and off since 10-15 days

AT ADMISSION:

Afebrile

PR: 86/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft



A 42 years old male patient Mr. YELLA REDDY SINGIREDDY came with c/o chest pain on and off since 10-15 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, EVOLVED ANTERIOR WALL MI, NO TLT, NORMAL LV SYSTOLIC FUNCTION, EF-60%, R/F: HTN , CORONARY ANGIOGRAM DONE ON 26/05/2022 - CAD-DVD (RCA, LAD), PTCA+DES TO LAD, RCA WITH 3.0 X 24 MM METAFOR TO LAD, 2.0 X 10 MM BALLOON TO RCA DONE ON 26/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. TIGATEL 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS
- 5) TAB. PROLOMET XL 25 MG ONCE DAILY AT 8AM TO CONTINUE.

#### REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.



ARH1.0001169013

EDIT

Name

Mr. G  
BHARGAV  
YADHAV

Patient Identifier

ARHIP55880

Age

56Yr  
4Mth  
29Days

Sex

Male

Date of  
Admission

26-May-  
2022

Date of Discharge

MLC No

Address

OBULAPUR MALLIAL  
JAGITIAL, Karimnagar, Telangana

Ward/  
Bed No

First  
Floor,  
CICU ,  
Bed  
no: CICU  
3

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, AWTMI, NO TLT, SR

MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%

R/F: HTN

CORONARY ANGIOGRAM DONE ON 16/10/2021 - CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.0 X 29 MM METAFOR DONE ON 16/10/2021

C/o SOB on exertion, chest pain since 5 days

AT ADMISSION:

Afebrile

PR: 79/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 52years old male patient Mr. GANDLA SHANKARAIHAH came with c/o SOB on exertion, chest pain since 5 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWTMI, MILD MR, SR, MILD LV DYSFUNCTION, EF-50%, CORONARY ANGIOGRAM DONE ON 16/10/2021 - CAD-SVD (LAD), Type-III vessel, proximal LAD significant stenosis. PTCA+DES TO LAD WITH 3.0 X 29 MM METAFOR DONE ON 16/10/2021. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASUDOC 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. SARTEL 40 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. FRUSELAC ONCE DAILY AT 2PM TO CONTINUE.
- 6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER /  
EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW  
REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL  
CENTER AT- 0878-2200000.

ARH1.0001231348

**Name**

Mrs. N LAXMI

**Patient Identifier**

ARHIP55875

**Age**

60Yr  
0Mth  
3Days

**Sex**

Female

**Date of Admission**

25-May-2022

**Date of Discharge  
MLC No**

**Address**

MANKAMMATHOTA  
KARIMNAGAR, Karimnagar, Telangana

**Ward/  
Bed No**

First  
Floor,  
CICU ,  
Bed  
no: CICU  
4

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, NSTEMI

NORMAL LV SYSTOLIC FUNCTION, EF-55%

R/F: HTN, T2DM, HYPOTHYROIDISM

CORONARY ANGIOGRAM DONE ON 25/05/2022 - CAD-DVD (RCA, LCX)

PTCA+DES TO RCA, LCX (2 STENTS) RCA WITH 3.0 X 38 MM XIENCE XPEDITION, LCX WITH 3.0 X 23 MM XIENCE XPEDITION DONE ON 25/05/2022

C/o chest pain since 7 days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 60 years old female patient Mrs. LAXMI came with c/o chest pain since 7 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, NORMAL LV SYSTOLIC FUNCTION, EF-55%, R/F: HTN, T2DM, HYPOTHYROIDISM, CORONARY ANGIOGRAM DONE ON 25/05/2022 - CAD-DVD (RCA, LCX), PTCA+DES TO RCA, LCX (2 STENTS) RCA WITH 3.0 X 38 MM XIENCE XPEDITION, LCX WITH 3.0 X 23 MM XIENCE XPEDITION DONE ON 25/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. AX CER 90MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. ROSEDAY 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. TELSAR 40MG ONCE DAILY AT 2PM TO CONTINUE.
- 5) TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 10 DAYS
- 6) TAB. GLYCOMET SR 500 MG ONCE DAILY AT 8AM TO CONTINUE.
- 7) TAB. STARPRESS XL 25 MG ONCE DAILY AT 8AM TO CONTINUE.
- 8) TAB. THYRORICH 150 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.



--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

APJ1.0002240508

<b>Name</b>		Mrs. MAHABOOB SULTANA	
<b>Patient Identifier</b>	ARHIP55914	<b>Age</b>	81Yr 0Mth 25Days
<b>Sex</b>	Female	<b>Date of Admission</b>	29-May-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	ZAREEN APARTMENTS DILSHAD NAGAR COLONY MEHDIPATNAM,Hyderabad,Telangana		
<b>Primary Consultant</b>	Dr Chandra Shekar Sathineni(MD (In		
		<b>Ward/ Bed No</b>	First Floor, MICU, Bed no:MICU 1

## DIABETIC KETOACIDOSIS

Complaint of uncontrolled sugars evaluation

Known case of hypertension, diabetic mellitus and CVA

AT ADMISSION:

Afebrile

PR: 74/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 100%

P/A: Soft, BS+

A 81 years old female patient Mrs. MAHABOOB SULTANA came with c/o uncontrolled sugars evaluation. All necessary investigations were done and diagnosed as DIABETIC KETOACIDOSIS. Managed conservatively. Patient attendants requested for discharge, hence patient is being discharge at request.

DISCHARGE MEDICATION:

-----

- 1) TAB. STROCIT 500 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS
- 2) TAB. CLOPILET 75 MG ONCE DAILY AT 2PM FOR 7 DAYS
- 3) TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM FOR 7 DAYS
- 4) TAB. ATORVA 40 MG ONCE DAILY AT 8PM FOR 7 DAYS
- 5) TAB. RAMIPRIL 2.5 MG ONCE DAILY AT 8AM FOR 7 DAYS
- 6) TAB. DAPAGLYN 10 MG ONCE DAILY AT 8AM FOR 7 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD



ARH1.0001231191

**Name**

Mr. LAXMAIAH M

**Patient Identifier** ARHIP55832

**Age** 60Yr  
0Mth  
8Days

**Sex** Male

**Date of Admission** 22-May-2022

**Date of Discharge**

**MLC No**

**Address** 3-92,DHARMAPURI ,  
DONURU,JAGITYAL,Karimnagar,Telangana

**Ward/Bed No** First  
Floor,  
MICU,  
Bed  
no:MICU  
9

**Primary Consultant** DR. SRI KARAN UDDESH --INTERNAL MEDICINE

URINARY TRACT INFECTION [ESBL, Ecoli]  
ALCOHOL WITHDRAWAL SYNDROME  
RIGHT CLAVICLE FRACTURE  
SEVERE HYPOKALAEMIA  
HYPOMAGNESAEMIA

C/o fever since 3 days associated with burning micturition

History of fall from bed to 3 days back at home

History of Pain at right shoulder region

AT ADMISSION:

Patient c/c

Febrile- Temp 101 F

PR: 120/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 21/min

SPO2: 93%

P/A: Soft

A 60 years old male patient Mr. LAXMAIAH M presented with the above-mentioned complaints patient was diagnosed as urinary tract infection and alcohol withdrawal syndrome, patient was treated with antibiotics Benzodiazepines and patient had dyselectrolytemia and corrective measures were given for hypokalaemia and hypocalcaemia. Patient's cognition improved since admission but patient is still in alcohol withdrawal as attenders are unwilling for further patient is discharged against medical advice.

ARH1.0001231381		<b>Name</b>	Ms. SHANTHA G
<b>Patient Identifier</b>	ARHIP55883	<b>Age</b>	67Yr 0Mth 4Days
<b>Sex</b>	Female	<b>Date of Admission</b>	26-May-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	VAVILALAPALLI, NEAR TEJA SCHOOL, Karimnagar, Telangana	<b>Ward/ Bed No</b>	First Floor, CICU , Bed no: CICU 8
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, NON ST ELEVATION MYOCARDIAL INFARCTION, NO TLT, SR

MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%

CORONARY ANGIOGRAM DONE ON 26/05/2022 - CAD-SVD (RCA)

PRIMARY PTCA+DES TO RCA WITH 2.75 X 11 MM BIO FREEDOM DONE ON 26/05/2022  
R/F: HTN, DM

C/o chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 93/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 67 years old female patient Ms. SHANTHA G came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NON ST ELEVATION MYOCARDIAL INFARCTION, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%, CORONARY ANGIOGRAM DONE ON 26/05/2022 - CAD-SVD (RCA), PRIMARY PTCA+DES TO RCA WITH 2.75 X 11 MM BIO FREEDOM [LOT NO: W21100017, S/N :210909929] DONE ON 26/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. AX CER 90MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) CAP. BEVON ONCE DAILY AT 2PM TO CONTINUE.
- 5) TAB. AZULIX-2 ONCE DAILY AT 7AM BEFORE BREAKFAST TO CONTINUE.
- 6) TAB. SGLTR ONCE DAILY AT 2PM BEFORE LUNCH TO CONTINUE.
- 7) TAB. VELOZ 20 MG ONCE DAILY AT 7AM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.



--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001231440

<b>Name</b>	Mrs. SAMALLA MUTHAMMA
<b>Patient Identifier</b>	ARHIP55898
<b>Sex</b>	Female
<b>Date of Discharge</b>	
<b>MLC No</b>	
<b>Address</b>	5-4-63, AMBEDKAR ROAD,JAGTIAL,Karimnagar,Telangana
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY
<b>Age</b>	72Yr 8Mth 3Days
<b>Date of Admission</b>	27-May-2022
<b>Ward/Bed No</b>	First Floor, CICU , Bed no:CICU 1

CORONARY ARTERY DISEASE, NON ST ELEVATION MYOCARDIAL INFARCTION, NO TLT, SR

MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%

CORONARY ANGIOGRAM DONE ON 30/05/2022 - CAD-DVD [LAD, RCA]

PLAN CABG.

C/o Retrosternal chest pain a/w SOB since 10 days

At Admission

Afebrile

PR: 62/min

BP: 130/70 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-96%

A 72 years old female patient Mrs. SAMALLA MUTHAMMA came with c/o retrosternal chest pain a/w SOB since 10 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NON ST ELEVATION MYOCARDIAL INFARCTION, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%, CORONARY ANGIOGRAM DONE ON 30/05/2022 – CAD-DVD [LAD, RCA], PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. RAMISTAR 1.25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 10 DAYS IN CARDIAC OPD

PRP

ARH1.0001231426

Name

Mr. BOJJA RAJA  
MOULI

Patient  
Identifier

ARHIP55893

Age

70Yr  
0Mth  
4Days

Sex

Male

Date of  
Admission

27-May-  
2022

Date of  
Discharge  
MLC No

30-May-2022

Address

KISAN NAGAR,Karimnagar,Telangana

Ward/Bed No

First  
Floor,  
MICU,  
Bed  
no:MICU  
4

Primary  
Consultant  
Surgeons

DR. SRI KARAN UDDESH --INTERNAL  
MEDICINE

Consultants

Anesthesiologi  
sts

Diagnosis

Diagnosis

Disease	Disease Type
SEPSIS(LRTI), AKI, PARAPLEGIA,PROBABLE MULTIPLE MYELOMA	

C/o left sided chest pain 15 days ago  
H/o Progressive dyspnoea since 15 days  
H/o Altered sensorium  
H/o Urinary incontinence

Known case of hypertension

AT ADMISSION:

Patient tachypnoeic , in altered sensorium  
PR: 109/min

BP: 90/60mmHg

RS: BAE+ [Bilateral wheeze, Bilateral crackles +]  
CNS - bilateral lower limbs power 0/5  
Tone-Hypotonia

Plantar-Mute

CVS: S1S2

RR: 20/min

SPO2: 91% on room air

P/A: Soft,

A 70 years old male Mr. BOJJA RAJA MOULI patient presented with above-mentioned complaints, on initial examination patient had bilateral lower limb weakness with power 0 /5 with paralysis, patient has had altered sensorium and labor to breathing. Patient was started on nebulisation and antibiotics. MRI spine and MRI brain were done, reports awaited, films were attached with summary. USG abdomen was done, which showed presence of right renal simple cortical cyst, cholelithiasis, bilateral grade-I renal parenchymal changes, Neurosurgeon and neurophysician consultations were taken and advices were followed. On day 2 of hospitalisation patient clinically improved and his sensorium was improved. On day 4 of hospitalisation patient saturation were suddenly dropped and became tachypnoeic, hence he was connected to NIV. Patient needs further hospitalisation and risk were explained, but patient attenders are willing to go another Hospital. Hence patient is being discharged against medical advice

ARH1.0001231335

**Name**

Mr.  
THIRUPATHI  
VADLAKONDA

**Patient Identifier**

ARHIP55869

**Age**

48Yr  
0Mth  
6Days

**Sex**

Male

**Date of  
Admission**

25-  
May-  
2022

**Date of Discharge**

**MLC No**

**Address**

H.NO:1-  
4,BEEERSANI,BUGGARAM,JAGITIAL,Other,Telanga  
na

**Ward/Bed  
No**

First  
Floor,  
CT  
POST,  
Bed  
no:CT  
1

**Primary Consultant**

Dr SOMASHEKAR K(MS,MCH

CORONARY ARTERY DISEASE+LMCA 100% BLOCK + MODERATE LV DYSFUNCTION +S/P AWMI

SURGERY – EMERGENCY CORONARY ARTERY BYPASS GRAFTING [SVG TO OM, LIMA TO LAD] FOR  
LMCA DONE ON 25/05/2022.

C/o retrosternal chest pain a/w sweating since 1 day

ON ADMISSION VITAL

-----

Patient conscious, coherent

Afebrile

PR-80/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 48 years old male patient Mr. THIRUPATHI VADLAKONDA presented to hospital with c/o retrosternal chest pain a/w sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE+LMCA 100% BLOCK + MODERATE LV DYSFUNCTION +S/P AWMI, SURGERY – EMERGENCY CORONARY ARTERY BYPASS GRAFTING FOR

LMCA DONE ON 25/05/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, PARADOXICAL SEPTAL MOTION, MODERATE LV SYSTOLIC DYSFUNCTION, NO PE/CLOT/VEG

BMI is 21.1 kg/m<sup>2</sup>.

Sr. Creatinine report on 26.05.2022 1.0 mg/dl.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. CLOPILET-A [75+150] ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. MET XL 25 MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. IVERZAC 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 4) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 6) TAB. ND-VIT ONCE DAILY AT 2PM TO CONTINUE.
- 7) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.
- 8) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.
- 9) TAB. CALPOL 500MG THRICE DAILY AT 8AM 2PM 8PM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD

ARH1.0001231490

**Name**

Mr. GOPAL  
SALLURI

**Patient Identifier**

ARHIP55923

**Age** 42Yr  
1Mth  
25Days

**Sex**

Male

**Date of Admission** 30-May-2022

**Date of Discharge  
MLC No**

**Address**

KMR,Karimnagar,Telangana

**Ward/  
Bed No** First  
Floor,  
MICU,  
Bed  
no:MICU  
5

**Primary Consultant**

DR. SUBRAT KUMAR SOREN --NEUROSURGERY

RTA  
CLOSED HEAD INJURY

Alleged history of RTA 2Wheeler vs 2 Wheeler at 9.40 pm near Kataram and sustained injury to head and left shoulder

History of ear and nosebleed represent

AT ADMISSION:

PR: 110/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 22/min

SPO2: 97%

P/A: Soft

GCS-15/15



A 42 years old male patient Mr. GOPAL SALLURI came with alleged history of RTA 2Wheeler vs 2 Wheeler at 9.40 pm near Kataram and sustained injury to head and left shoulder, history of ear and nosebleed represent. All necessary investigations were done and diagnosed as RTA, CLOSED HEAD INJURY. Managed conservatively. Orthopaedic consultation taken and advised followed. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. LEVIPIL 500 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS
2. TAB. NAXDOM 250 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS
3. TAB. PANTOP 40MG ONCE DAILY AT 7AM (BBF) FOR 7 DAYS.
4. TAB. AUGMENTIN 625 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS
5. TAB. TOLPERITES-D **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS
6. SOFT CERVICAL COLLAR FOR 7 DAYS

REVIEW AFTER 7 DAYS IN NEUROSURGERY OPD

55911 v rajaiah

CORONARY ARTERY DISEASE, ACUTE INFERIOR WALL MIOCARDIAL INFARCTION, SR  
NORMAL LV SYSTOLIC FUNCTION, EF-54%

R/F: HTN, CHRONIC SMOKER

CORONARY ANGIOGRAM DONE ON 29/05/2022 - CAD-SVD (RCA)

PRIMARY PTCA+DES TO RCA WITH 3.0 X 37 MM METAFOR DONE ON 29/05/2022

C/o Retrosternal chest pain a/w mild sweating since 1 day

AT ADMISSION:

Afebrile

PR: 75/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 50 years old male patient Mr. V RAJIAH came with c/o Retrosternal chest pain a/w mild sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE INFERIOR WALL MIOCARDIAL INFARCTION, SR, NORMAL LV SYSTOLIC FUNCTION, EF-54%, R/F: HTN, CHRONIC SMOKER, CORONARY ANGIOGRAM DONE ON 29/05/2022 – CAD-SVD (RCA), PRIMARY PTCA+DES TO RCA WITH 3.0 X 37 MM METAFOR [LOT NO: MG80, S/N :CM37MG80008] DONE ON 29/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASUDOC 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS
- 5) TAB. PROLOMET R 25MG ONCE DAILY AT 8AM TO CONTINUE.

#### REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001231536

<b>Name</b>	Mr. MARK AJAY
<b>Patient Identifier</b>	ARHIP55938
<b>Age</b>	32Yr 0Mth 1Days
<b>Sex</b>	Male
<b>Date of Admission</b>	31-May- 2022
<b>Date of Discharge</b>	
<b>MLC No</b>	
<b>Address</b>	ANNAPURNA COLONY , PEDDAPALLY,Ramagundam,Telanga na
<b>Ward/Bed No</b>	First Floor, MICU, Bed no:MIC U 9
<b>Primary Consultant Surgeons</b>	DR. SUBRAT KUMAR SOREN -- NEUROSURGERY
<b>Consultants</b>	
<b>Anesthesiologists</b>	

RTA  
TRAUMATIC BAIN INJURY  
ACUTE SDH & TRAUMATIC SAH  
MULTIPLE HAEMORRHAGIC CONTUSIONS  
FRACTURE BONE 5<sup>TH</sup> METAPHALYNGEAL LEFT

Alleged history of RTA 2Wheeler vs 2 Wheeler at 8.30 pm on 30/05/2022 near Peddapally and sustained injury to head, left hand and left lower limb

AT ADMISSION:

PR: 110/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 94%

P/A: Soft

GCS-E2, V3, M5

A 32 years old male patient Mr. MARK AJAY came with alleged history of RTA 2Wheeler vs 2 Wheeler at 8.30 pm on 30/05/2022 near Peddapally and sustained injury to head, left hand and left lower limb. All necessary investigations were done and diagnosed as RTA, TRAUMATIC BRAIN INJURY, ACUTE SDH & TRAUMATIC SAH, MULTIPLE HAEMORRHAGIC CONTUSIONS, FRACTURE BONE 5<sup>TH</sup> METAPHALYNGEAL LEFT. Orthopaedic consultation taken and advice followed. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA.

ARH1.0001231488

<b>Name</b>	Mr. M SAMPATH KUMAR		
<b>Patient Identifier</b>	ARHIP55921	<b>Age</b>	28Yr 0Mth 2Days
<b>Sex</b>	Male	<b>Date of Admission</b>	30-May-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	GALIPALLY,Karimnagar,Telangana	<b>Ward/ Bed No</b>	First Floor, CICU , Bed no:CICU 4
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, NON ST ELEVATION MYOCARDIAL INFARCTION, SR  
MILD LV SYSTOLIC DYSFUNCTION [EF-50%]

CORONARY ANGIOGRAM (31/05/2022) -NORMAL CORONARIES

PLAN MEDICAL MANAGEMENT

C/o chest pain a/w SOB, sweatings since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 28 years old male patient Mr. M SAMPATH KUMAR came with c/o chest pain a/w SOB, sweatings since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NON ST ELEVATION MYOCARDIAL INFARCTION, SR, MILD LV SYSTOLIC DYSFUNCTION [EF-50%], CORONARY ANGIOGRAM (31/05/2022) -NORMAL CORONARIES, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001231569		<b>Name</b>	Mr. B LAXMAIAH
<b>Patient Identifier</b>	ARHIP55953	<b>Age</b>	65Yr 0Mth 1Days
<b>Sex</b>	Male	<b>Date of Admission</b>	01-Jun-2022
<b>Date of Discharge</b>	01-Jun-2022		
<b>MLC No</b>			
<b>Address</b>	KARIMNAGAR,Karimnagar,Telangana	<b>Ward/Bed No</b>	Ground Floor, Emergency Ward, Bed no:EME4
<b>Primary Consultant Surgeons</b>	DR. SANJAY KUMAR KAMINWAR(MD,DM(Neurology),Consultant Neuro Physician)--NEUROLOGY	<b>Consultants</b>	
		<b>Anesthesiologi</b>	



sts

Diagnosis

**Diagnosis**

Disease	Disease Type
CVA -ACUTE LEFT MCA INFARCT THROBOLISED WITH TPA (TENECTASE )WITH ACUTE RE INFARCT IN LEFT MCA.	

C/o Sudden onset weakness of right upper limb, facial deviation to right

AT ADMISSION:

Afebrile

PR: 98/min

BP: 190/100mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 100%

P/A: Soft,

A 65 years old male patient Mr. LAXMAIAH came with c/o sudden onset weakness of right upper limb, facial deviation to right. All necessary investigations were done and diagnosed as CVA -ACUTE LEFT MCA INFARCT THROBOLISED WITH TPA (TENECTASE )WITH ACUTE RE INFARCT IN LEFT MCA. Thrombolised with INJ. TENECTASE 14 mg IV slowly over 1 minute, power of 5 /5 developed in right side after 5 minutes of thrombolisation. After 3 hours power again deteriorated to upper limb 0/ 5 and lower limb 1 /5 of right side. Post thrombolysis MRI done suggestive of acute left MCA territory infarct (ischaemic on etiology) . Patient attendants requested for discharge, patient referred to Higher Centre for further management.

ARH1.0001231478

Name

Mr. THULALA RAVI

Patient Identifier

ARHIP55915

Age

37Yr  
0Mth  
2Days

Sex

Male

Date of

Admission

29-May-  
2022

Expired Date

31-May-2022

MLC No

Address

velgatoor,Karimnagar,Telangana

Ward/Bed No

First  
Floor,  
CICU ,  
Bed  
no:CICU2

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

Consultants

Surgeons

Anesthesiologi  
sts

Diagnosis  
S

Diagnosis

Disease	Disease Type
AKI WITH VIRAL FEVER WITH SEPTIC SHOCK	

C/o severe SOB since 3 days

AT ADMISSION:

PR: 110/min

BP: Not recordable

RS: BAE+

CVS: S1S2

RR: 21/min

SPO2: 98%

P/A: Soft

A 37 years old male patient Mr. THULALA RAVI came with c/o severe SOB since 3 days. All necessary investigations were done and diagnosed as AKI WITH VIRAL FEVER WITH SEPTIC SHOCK. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and inotropic support was given. CPR started immediately, continued for 40 minutes, according to ACLs

guidelines. Patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 09.15 AM on 29/05/2022.

#### CAUSE OF DEATH

-----

AKI WITH VIRAL FEVER WITH SEPTIC SHOCK

ARH1.0001231439

**Name**

Mrs. KOTHAPELLY  
PADMA

**Patient Identifier** ARHIP55926

**Age** 42Yr 0Mth  
5Days

**Sex** Female

**Date of Admission** 30-May-2022

**Date of Discharge**  
**MLC No**

**Address** 1-  
1,GOLLAPALLI,JAGTIAL,Karimnagar,Telangana

**Ward/Bed No** First  
Floor,  
CICU ,  
Bed  
no:CICU1  
1

**Primary Consultant** Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, NSTEMI

NORMAL LV SYSTOLIC DYSFUNCTION [EF-60%]

CORONARY ANGIOGRAM (01/06/2022) -NORMAL CORONARIES

PLAN MEDICAL MANAGEMENT

C/o chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 42 years old female patient Mrs. KOTHAPELly PADMA came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, NORMAL LV SYSTOLIC DYSFUNCTION [EF-60%], CORONARY ANGIOGRAM (01/06/2022) -NORMAL CORONARIES, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPITAB 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. ANGISPAN-TR **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. TELMA-CT 40/6.25 MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. CILACAR 10 MG ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. ENCORATE 200 MG ONCE DAILY AT 8PM TO CONTINUE.
8. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001231104		Name	Mr. G VAMSHI
Patient Identifier	ARHIP55803	Age	25Yr 0Mth 14Days
Sex	Male	Date of Admission	20-May-2022
Date of Discharge			
MLC No			

<b>Address</b>	THOMBARAOPET JAGITIAL,Karimnagar,Telangan a	<b>Ward/Bed No</b>	First Floor, SICU, Bed no:SICU 3
<b>Primary Consultant</b>	DR. SUBRAT KUMAR SOREN --NEUROSURGERY	<b>Consultants</b>	
<b>Surgeons</b>	DR. SUBRAT KUMAR SOREN --NEUROSURGERY	<b>Anesthesiologists</b>	Dr Subba Reddy Kuppannagari-- ANAESTHESIOLOGY

## Diagnosis

### Diagnosis

[Add  
Diagnosis](#)

ARHIP55803	ARH1.000123110
------------	----------------

## Surgery / Procedures Done

### Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
	21			

ROAD TRAFFIC ACCIDENT, SEVERE HEAD INJURY

DIFFUSE AXONAL INJURY [GRADE II-III]

ACUTE EDH (SMALL) ON RIGHT FRONTAL REGION

ACUTE THIN SDH LEFT TEMPORAL REGION

MULTIPLE HAEMORRHAGIC CONTUSIONS LEFT TEMPORAL LOBE

DIFFUSE CEREBRAL EDEMA WITH LEFT LATERAL VENTRICLE EFFACEMENT

POST TRAUMATIC DELAYED SEIZURE

RIGHT HEMIPARESIS

S/P: LEFT FTP DECOMPRESSIVE CRANIECTOMY DONE ON 21/05/2022

Alleged history of RTA 2Wheeler vs 2 Wheeler around 7.00 pm on 19/05/2022 and sustained injury to head.  
History of LOC+, initially treated at outside hospital and came here for further management

AT ADMISSION:

Patient is drowsy

PR: 113/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 32/min

SPO2: 97%

P/A: Soft

GCS-E2,V5,M6

TREATMENT GIVEN:

Injectable antiepileptic, antibiotics (Meropenem, Linezolid) antiedema measures, analgesics and other supportive treatment given

A 25 years old male patient Mr. G VAMSHI came with alleged history of RTA 2Wheeler vs 2 Wheeler around 7.00 pm on 19/05/2022 and sustained injury to head, history of LOC+, Initially treated at outside hospital and came here for further management. All necessary investigations were done and diagnosed as ROAD TRAFFIC ACCIDENT, SEVERE HEAD INJURY, DIFFUSE AXONAL INJURY [GRADE II-III], ACUTE EDH (SMALL) ON RIGHT FRONTAL REGION, ACUTE THIN SDH LEFT TEMPORAL REGION, MULTIPLE HAEMORRHAGIC CONTUSIONS LEFT TEMPORAL LOBE, DIFFUSE CEREBRAL EDEMA WITH LEFT LATERAL VENTRICLE EFFACEMENT, POST TRAUMATIC DELAYED SEIZURE, RIGHT HEMIPARESIS, S/P: LEFT FTP DECOMPRESSIVE CRANIECTOMY DONE ON 21/05/2022. Postoperative period was uneventful. Patient developed fever, empirical appropriate antibiotics given. Now patient is haemodynamically stable, Afebrile, no evidence of active seizure, SPO2 maintained at room air. GCS-E2 V3 M5, pupil-b/l reacting to light. Patient attendants explained regarding further Neurorehabilitation, travel risk and associated further deterioration. Hence patient is being discharged.

ARH1.0001231402

Name

Mr. K MONDAIAH

**Patient Identifier** ARHIP55958

**Age** 43Yr  
0Mth  
7Days

**Sex** Male

**Date of Admission** 01-Jun-2022

**Date of Discharge**  
**MLC No**

**Address** BUGGARAM, JAGITYAL, Karimnagar, Telangana

**Ward/Bed No** First Floor, Day Care, Bed no: DC 3

**Primary Consultant** Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, UNSTABLE ANGINA, NO TLT, SR  
NORMAL LV SYSTOLIC FUNCTION, EF-60%  
S/P CORONARY ANGIOGRAM DONE ON 01/06/2022 - CAD-LM  
PLAN CABG.

C/o chest pain since 1 day

At Admission

Afebrile

PR: 82/min

BP: 120/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-96%



A 43 years old male patient Mr. K MONDAIAH came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, NO TLT, SR, NORMAL LV SYSTOLIC FUNCTION, EF-60%, S/P CORONARY ANGIOGRAM DONE ON 01/06/2022 - CAD-LM, PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB. NOVASTAT 40 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. BETALOC 50 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. PANTOCID 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

REVIEW AFTER 7 DAYS IN CARDIAC OPD



ARH1.0001087117		Name	Mr. ANNADI SANJEEVA REDDY
Patient Identifier	ARHIP55936	Age	80Yr 9Mth 26Days
Sex	Male	Date of Admission	31-May-2022
Expired Date	01-Jun-2022		
MLC No			
Address	SHATHRAJ PALLI,VEMULAWADA,Karimnagar,Telangana	Ward/Bed No	First Floor, MICU, Bed no:MICU 3
Primary Consultant	Dr. RAMCHANDER TORREM(MD (General Medicine),DM Nephrology(NIMS),Consultant Nephrologist)--NEPHROLOGY	Consultants	
Surgeons		Anesthesiologists	

Diagnosis

Diagnosis

[Add Diagnosis](#)

Disease	Disease Type
---------	--------------

ACUTE ON CKD, SEPTIC SHOCK

ARH1.0001231570

**Name**

Mr. ABHIRAM B

**Patient Identifier**

ARHIP55955

**Sex**

Male

**Date of Discharge  
MLC No**

**Address**

POOSALA ROAD, SULTHANABAD,  
KARIMNAGAR,Telangana

**Primary Consultant**

Dr. GOUTHAM ROY (MS

**Age**

24Yr 0Mth  
1Days

**Date of Admission**

01-Jun-2022

**Ward/  
Bed No**

First Floor,  
RECOVERY  
ROOM, Bed  
no:RR 4

## GALLSTONE DISEASE

SURGERY: LAPROSCOPIC CHOLECYSTECTOMY DONE ON 01.06.2022

C/o abdomen distension, nausea, discomfortness in abdomen since 5 days  
H/o Appendicitis in 2012

## PHYSICAL EXAMINATION:

### ON ADMISSION

-----

Pt c/c/c

afebrile

PR-82/min

BP-120/80mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 24 yr old male patient <sup>ABHIRAM</sup> came with c/o abdomen distension, nausea, discomfortness in abdomen since 5 days. All necessary investigations done and diagnosed as GALLSTONE DISEASE, SURGERY: LAPROSCOPIC CHOLECYSTECTOMY DONE ON 01.06.2022. Findings: Well distended gallbladder with well defined calot's. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

#### DISCHARGE MEDICATION:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. TAB: SOMPRAZ-L TWICE DAILY AT 8AM, 8PM FOR 15 DAYS
5. GLUTAVALT SACHETS ONCE DAILY AT 8AM WITH GLASS OF WATER FOR 15 DAYS.

Review after 7 days in General Surgery OPD.

ARH1.0001231475

**Name**

Mr.  
GAFFAR  
MD

**Patient Identifier**

ARHIP55912

**Age** 34Yr  
0Mth  
4Days

**Sex**

Male

**Date of Admission** 29-May-2022

**Date of Discharge**  
**MLC No**

**Address**

KMR,Karimnagar,Telangana

**Ward/Bed No** First  
Floor,  
CICU ,  
Bed  
no:CICU  
2

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE AWMI

TLT DONE OUT SIDE WITH INJ. TENECTEPLASE

NORMAL LV SYSTOLIC DYSFUNCTION [EF-60%]

CORONARY ANGIOGRAM (01/06/2022) -CAD-SVD (proximal LAD ecatic-  
Recanalised)

PLAN MEDICAL MANAGEMENT

C/o Retrosternal chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 34 years old male patient Mr. GAFFAR MD came with c/o retrosternal chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AAWMI, TLT DONE OUT SIDE WITH INJ. TENECTEPLASE, NORMAL LV SYSTOLIC DYSFUNCTION [EF-60%], CORONARY ANGIOGRAM (01/06/2022) -CAD-SVD (proximal LAD ecatic-Recanalised), PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ROZAVEL 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001231554

**Name**

Mrs.  
AMISHETTI  
VENKATAMMA

**Patient Identifier**

ARHIP55946

**Age**

56Yr  
4Mth  
2Days

**Sex**

Female

**Date of  
Admission**

31-May-  
2022

**Date of Discharge  
MLC No**

**Address**

2-20/A,  
THEEGALAGUTTAPALLY, Karimnagar, Telangan  
a

**Ward/Bed  
No**

First  
Floor,  
CICU ,  
Bed  
no: CICU  
1

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, NSTEMI, NO TLT, SR

MILD LV SYSTOLIC DYSFUNCTION, EF-45%

S/P CORONARY ANGIOGRAM DONE ON 01/06/2022 - CAD-LM+TVD, [LAD, RCA, LCX]

PLAN CABG.

R/F HTN, DM

C/o chest pain since 1 day

At Admission

Afebrile

PR: 82/min

BP: 120/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-96%



A 56 years old female patient Mrs. AMISHETTI VENKATAMMA came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, NO TLT, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-45%, S/P CORONARY ANGIOGRAM DONE ON 01/06/2022 – CAD-LM+TVD, [LAD, RCA, LCX], PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 75 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. METOLAR-XR 25 MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0001010608

**Name**

Mr. J  
RAGHUPATHI

**Patient Identifier**

ARHIP55957

**Age**

64Yr 9Mth  
29Days

**Sex**

Male

**Date of  
Admission**

01-Jun-  
2022

**Date of Discharge**

**MLC No**

**Address**

4-73/8 SARASWATHI NGAR  
THEEGALAGUTTAPALLI, Karimnagar, Andhra  
Pradesh

**Ward/Bed  
No**

First  
Floor,  
CICU ,  
Bed  
no: CICU1  
3

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, NSTEMI, NO TLT, SR

NORMAL LV SYSTOLIC FUNCTION, EF-55%

S/P CORONARY ANGIOGRAM DONE ON 01/06/2022 - CAD-SVD-[LAD]

PLAN CABG.

R/F HTN, HYPOTHYROID

K/C/O THROMBOCYTOPENIA

C/o chest pain since 4-5 days a/w SOB, generalized weakness

At Admission

Afebrile

PR: 82/min

BP: 110/70 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-96%

A 64 years old male patient <sup>RAGHUPATHI</sup> came with c/o chest pain since 4-5 days a/w SOB, generalized weakness. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, NO TLT, SR, NORMAL LV SYSTOLIC FUNCTION, EF-55%, S/P CORONARY ANGIOGRAM DONE ON 01/06/2022 - CAD-SVD-[LAD], PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB. NOVASTAT 40 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. TIGATEL 40 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. MONIT-GTN 2.6 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. THYRONORM 150 MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC

M SAI NATH 32      55966

CHIN LACERATION SECONDARY TO RTA  
SURGERY: SUTURING OF CHIN LACERATION DONE ON 02.06.2022

Alleged history of RTA 2 Wheeler versus 4 Wheeler on 01/06/2022 at 5 pm  
History of right Ear bleed +

PHYSICAL EXAMINATION:

ON ADMISSION

-----

Pt c/c/c

afebrile

PR-94/min

BP-130/80mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-99%

A 32 yrs old male patient SAINATH came with alleged history of RTA 2 Wheeler versus 4 Wheeler on 01/06/2022 at 5 pm, history of right Ear bleed +. All necessary investigations done and diagnosed as CHIN LACERATION SECONDARY TO RTA, SURGERY: SUTURING OF CHIN LACERATION DONE ON 02.06.2022. Findings: Laceration measuring 4 x 2 cm noted in the lower level of chin. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
3. TAB: ROTAVAUULT THRICE DAILY AT 8AM, 2PM, 8PM FOR 5 DAYS.
4. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
5. GLUTAVAUULT SACHETS ONCE DAILY AT 8AM WITH GLASS OF WATER FOR 15 DAYS.
6. T-BACT OINTMENT FOR L/A

Review after 7 days in General Surgery OPD.

55918

ARH1.0001218477

**Name**

Mrs. LAXMI P

**Patient Identifier** ARHIP55918

**Age** 86Yr  
5Mth  
2Days

**Sex** Female

**Date of Admission** 29-May-2022

**Date of Discharge**  
**MLC No**

**Address** NTPC,JYOTHINAGAR,,Ramagundam,Telangana

**Ward/ Bed No** First Floor, CICU , Bed no:CICU 9

**Primary Consultant** Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, AWTMI, NO TLT, SR

SEVERE LV DYSFUNCTION [EF-30%]

S/P RIGHT FEMUR NAILING (2021)

RIGHT IT FRACTURE

R/F : HTN

C/o chest pain a/w SOB grade-3 since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 85/min

BP: 100/70mmHg

RS: BAE+

CVS: S1S2

RR: 19/min

SPO2: 92% on room air

P/A: Soft

A 86 years old female patient P. LAXMI came with c/o chest pain a/w SOB grade-3 since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWTMI, NO TLT, SR, SEVERE LV DYSFUNCTION [EF-30%], S/P RIGHT FEMUR NAILING (2021), RIGHT IT FRACTURE. Managed conservatively. Patient is being discharged in hemodynamically stable condition with required medication and advise.

#### DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. AX CER 90MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 9PM TO CONTINUE.
4. TAB. CONCOR 2.5 MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. RAMISTAR 2.5 MG ONCE DAILY AT 8PM TO CONTINUE.
6. TAB. DYTOR PLUS LS ONCE DAILY AT 8AM TO CONTINUE.
7. TAB: NEXPRO 20MG ONCE DAILY AT 7AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001230273

**Name**

Mr. LACHAIAH  
AMSHALA

**Patient Identifier** ARHIP55932

**Age** 47Yr  
1Mth  
9Days

**Sex** Male

**Date of Admission** 30-May-2022

**Date of Discharge**  
**MLC No**

**Address** MALLAPUR,DHARMARAM,Other,Telangana

**Ward/Bed No** First Floor, CICU , Bed no:CICU 2

**Primary Consultant** Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

SEVERE LV DYSFUNCTION, EF-30%

CORONARY ANGIOGRAM DONE ON 28/04/2022 - CAD-SVD (LAD)

PTCA+DES TO LAD WITH 4.0 X 28 MM 3V ASTRA DONE ON 31/05/2022

C/o chest pain since 1 month

AT ADMISSION:

Afebrile

PR: 81/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft



A 47years old male patient Mr. LACHAIAH came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWTMI, NO TLT, SR, SEVERE LV DYSFUNCTION, EF-30%, CORONARY ANGIOGRAM DONE ON 28/04/2022 - CAD-SVD (LAD), PTCA+DES TO LAD WITH 4.0 X 28 MM 3V ASTRA [LOT NO: 220940028011A, S/N :20096281006] DONE ON 31/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASITA UDOC 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. SARTEL 40 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. FRUSELAC ONCE DAILY AT 2PM TO CONTINUE.
- 6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001231550

<b>Name</b>	Mr. GANGADHARA MALLESHAM		
<b>Patient Identifier</b>	ARHIP55941	<b>Age</b>	46Yr 1Mth 2Days
<b>Sex</b>	Male	<b>Date of Admission</b>	31-May-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	7-12,SRIRAMULAPALLI,KODIMIAL,JAGTIAL,Karimnagar,Telangana	<b>Ward/Bed No</b>	First Floor, CICU , Bed no:CICU10
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE LATERAL WALL MI, NO TLT, SR

MILD LV DYSFUNCTION, EF-47%

CORONARY ANGIOGRAM DONE ON 31/05/2022 - CAD-DVD (LAD, LCX)

PRIMARY ANGIOPLASTY TO OM1 & D1 [THROMBUS ASPIRATION] DONE, TIMI III FLOW ACHIEVED ON 31/05/2022

C/o chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 80/min

BP: 100/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 46years old male patient Mr. GANGADHARA MALLESHAM came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE LATERAL WALL MI, NO TLT, SR, MILD LV DYSFUNCTION, EF-47%, CORONARY ANGIOGRAM DONE ON 31/05/2022 – CAD-DVD (LAD, LCX), PRIMARY ANGIOPLASTY TO OM1 & D1 [THROMBUS ASPIRATION] DONE, TIMI III FLOW ACHIEVED ON 31/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 75 MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. BRILINTA 90MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. ROSUVAS 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. VELOZ 20 MG ONCE DAILY AT 8AM TO CONTINUE.

#### REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001230273

<b>Name</b>		Mr. LACHAIAH AMSHALA	
<b>Patient Identifier</b>	ARHIP55932	<b>Age</b>	47Yr 1Mth 9Days
<b>Sex</b>	Male	<b>Date of Admission</b>	30-May-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	MALLAPUR,DHARMARAM,Other,Telangana		
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY		
		<b>Ward/ Bed No</b>	First Floor, CICU , Bed no:CICU 2

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

SEVERE LV DYSFUNCTION, EF-30%

CORONARY ANGIOGRAM DONE ON 28/04/2022 - CAD-SVD (LAD)

PTCA+DES TO LAD WITH 4.0 X 28 MM 3V ASTRA DONE ON 31/05/2022

C/o chest pain since 1 month

AT ADMISSION:

Afebrile

PR: 81/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 47years old male patient Mr. LACHAIAH came with c/o chest pain since 1 month. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR, SEVERE LV DYSFUNCTION, EF-30%, CORONARY ANGIOGRAM DONE ON 28/04/2022 – CAD-SVD (LAD), PTCA+DES TO LAD WITH 4.0 X 28 MM 3V ASTRA [LOT NO: 220940028011A, S/N :20096281006] DONE ON 31/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASITA 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. TONACT 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. BETALOC 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 5) TAB. FRUSELOC ONCE DAILY AT 8PM TO CONTINUE.
- 6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS
- 7) TAB. FEBUTAZ 40 MG ONCE DAILY AT 2PM FOR 7 DAYS
- 8) TAB. GOUTNIL 0.5 MG ONCE DAILY AT 2PM FOR 7 DAYS

#### REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.



ARH1.0001224965		<b>Name</b>	Mr. S VENKATAIAH
<b>Patient Identifier</b>	ARHIP55979	<b>Age</b>	86Yr 5Mth 30Days
<b>Sex</b>	Male	<b>Date of Admission</b>	02-Jun-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	ALGUNOOR,Karimnagar,Telangana	<b>Ward/Bed No</b>	First Floor, MICU, Bed no:MICU 12
<b>Primary Consultant</b>	DR. NIKHIL GOLI --NEUROLOGY		

S

HYPOGLYCEMIA, SEIZURES DISORDER  
K/C/O HYPERTENSION, TYPE II DIABETES MELLITUS

C/o gradual decrease of level of consciousness since 1 day

AT ADMISSION:

Afebrile

PR: 94/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 95%

P/A: Soft

A 86 years old male patient **Mr. VENKATAIAH** came with c/o gradual decrease of level of consciousness since 1 day. All necessary investigations were done and diagnosed as HYPOGLYCEMIA, SEIZURES DISORDER, K/C/O HYPERTENSION, TYPE II DIABETES MELLITUS. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB: TELMA-AM ONCE DAILY AT 8AM TO CONTINUE
2. TAB: SPINFREE 25MG THRICE DAILY AT 8AM 2PM AND 8PM TO CONTINUE
3. TAB: LEVIPIL 500MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE

REVIEW AFTER 7 DAYS IN DR. NIKHIL GOLI sir OPD.

ARH1.0001231640

**Name**

Mr. B KANAKAIAH

**Patient Identifier** ARHIP55971

**Age** 64Yr  
0Mth  
1Days

**Sex** Male

**Date of Admission** 02-Jun-2022

**Date of Discharge**  
**MLC No**

**Address** GODAVARIKHANI,Karimnagar,Telangana

**Ward/Bed No** First Floor, CICU , Bed no:CICU 8

**Primary Consultant** Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE AWM

NORMAL LV SYSTOLIC FUNCTION [EF-60%]

CORONARY ANGIOGRAM (02/06/2022) -CAD-Mild disease

PLAN MEDICAL MANAGEMENT

R/F : HTN, HYPOTHYROID

C/o chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 64 years old male patient <sup>KANAKAIAH</sup> came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWTMI, NORMAL LV SYSTOLIC FUNCTION [EF-60%], CORONARY ANGIOGRAM (02/06/2022) -CAD-Mild disease, PLAN MEDICAL MANAGEMENT. General Physician Consultation taken and advice followed. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. CLOPITAB 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. NOVASTAT 40MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. TELMA 40MG ONCE DAILY AT 8AM TO CONTINUE.
4. TAB. NEXPRO 40MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. THYRONORM 200MCG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

REVIEW AFTER 7 DAYS TO GENERAL MEDICINE OPD WITH FT4, TSH, Anti TPO antibodies reports

ARH1.0001231559

**Name**

Mrs. ANKAM  
SAROJANA

**Patient Identifier** ARHIP55949

**Age** 49Yr 3Mth  
0Days

**Sex** Female

**Date of Admission** 31-May-2022

**Date of Discharge**  
**MLC No**

**Address** 17-23/A,  
MANTHANI, PEDDAPALLI, Karimnagar, Telangana

**Ward/Bed No** First  
Floor,  
CICU ,  
Bed  
no: CICU1  
1

**Primary Consultant** Dr. Vidya Sagar A--CARDIOLOGY

CRHD

SEVERE MITRAL STENOSIS [EF-60%]

CORONARY ANGIOGRAM (02/06/2022) -NORMAL CORONARIES

PLAN FOR MVR

C/o palpitations a/w grade-2 SOB since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 49 years old female patient Mrs. ANKAM SAROJANA came with c/o palpitations a/w grade-2 SOB since 1 day. All necessary investigations were done and diagnosed as CRHD, SEVERE MITRAL STENOSIS [EF-60%], CORONARY ANGIOGRAM (02/06/2022) - NORMAL CORONARIES, PLAN FOR MVR. CTVS consultation taken and advised MVR. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. MET-XL 25MG ONCE DAILY AT 8AM TO CONTINUE.
2. TAB. DYTOR PLUS 5MG ONCE DAILY AT 8AM TO CONTINUE.
3. TAB. LANOXIN 0.25MG ½ TAB ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001231622

Name

Mr.  
MANOHAR  
N

Patient Identifier

ARHIP55975

Age

50Yr  
0Mth  
2Days

Sex

Male

Date of  
Admission

02-Jun-  
2022

Date of Discharge

MLC No

Address

SARASWATHINAGAR, ROAD  
NO:3,Karimnagar,Telangana

Ward/  
Bed No

Second  
Floor,  
Semi  
Private,  
Bed  
no:120  
A

Primary Consultant

Dr Chandra Shekar Sathineni(

ACUTE GASTROENTERITIS  
DIABETES MELLITUS

C/o loose motions, vomitings since 2 days

AT ADMISSION:

Afebrile

PR: 87/min

BP: 100/60 mmHg

RS: BAE+

CVS: S1S2

RR: 21/min

SPO2: 99%

P/A: Soft

A 50 years old male patient Mr. MANOHAR N came with c/o loose motions, vomitings since 2 days. All necessary investigations were done and diagnosed as ACUTE GASTROENTERITIS, DIABETES MELLITUS. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. INJ. HUMAN MIXTARD 30 /70 40 UNITS AT 8AM, 20 UNITS AT 8 PM TO CONTINUE
2. TAB. ARVAST-CV ONCE DAILY AT 8 PM FOR 10 DAYS
3. TAB. GLUCO-Q10 ONCE DAILY AT 2 PM FOR 10 DAYS
4. TAB. RAZO-L ONCE DAILY AT 8 AM FOR 15 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD



ARH1.0001227237

**Name**

Mr.  
MOHAMMAD  
ISMAIL BAIG

**Patient Identifier**

ARHIP55928

**Age**

65Yr  
4Mth  
5Days

**Sex**

Male

**Date of  
Admission**

30-  
May-  
2022

**Date of Discharge**

**MLC No**

**Address**

HOUSE NO: 5-5-108 STREET: GUNJ STREET  
DISTRICT: JAGTIAL,Telangana

**Ward/Bed  
No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:118  
C

**Primary Consultant**

Dr. SURESH GOUD S(MS

PROSTATOMEGALY + STRICTURE URETHRA  
SURGERY: TURP + OPTICAL URETHRATOMY DONE ON 31/05/2022

C/o difficulty in passing urine since 1 week

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

All required investigations done and enclosed

A 65 yrs old male patient Mr. MOHAMMAD ISMAIL BAIG came to the hospital with c/o difficulty in passing urine since 1 week. All necessary investigations done and diagnosed as PROSTATOMEGALY + STRICTURE URETHRA, SURGERY: TURP + OPTICAL URETHRATOMY DONE ON 31/05/2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB: ROXSAFE CV 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: FAMOCID 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: NDQ10 ONCE DAILY AT 2PM FOR 10 DAYS
5. SYP: K-CIT 10 ml TWICE DAILY AT 8AM, 8PM

REVIEW AFTER 11 DAYS TO UROLOGY OPD



ARH1.0001208211

**Name**

Mr. GOLLA  
RAVI

**Patient Identifier**

ARHIP55969

**Age** 44Yr 5Mth  
3Days

**Sex**

Male

**Date of Admission** 02-Jun-  
2022

**Date of Discharge**

**MLC No**

**Address**

7-4-  
321,KASHMEERGADDA,Karimnagar,Telangana

**Ward/  
Bed No** First Floor,  
RECOVERY  
ROOM, Bed  
no:RR 5

**Primary Consultant**

Dr. GOUTHAM ROY (MS)

GRADE-IV INTERNAL HEMORRHOIDS  
SURGERY: OPEN HEMORRHOIDECTOMY DONE ON 02/06/2022

C/o per rectum bleeding, mild constipation since 3 months

PHYSICAL EXAMINATION:

ON ADMISSION

-----

Pt c/c/c

afebrile

PR-82/min

BP-110/70mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

SPO2-100%

A 44 yrs old male patient Mr. GOLLA RAVI came with c/o per rectum bleeding, mild constipation since 3 months. All necessary investigations done and diagnosed as GRADE-IV INTERNAL HEMORRHOIDS, SURGERY: OPEN HEMORRHOIDECTOMY DONE ON 02/06/2022. Findings: Multiple internal hemorrhoids noted in the anal canal @ 3'O, 7'O & 4'O clock in position. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
2. TAB: ND Q10 ONCE DAILY AT 2PM FOR 30 DAYS.
3. GLUTAVAUULT -V SACHETS ONCE DAILY AT 8AM WITH GLASS OF WATER FOR 15 DAYS.
4. SYP. LACTIHEP 3 TSP ONCE IN A DAY AT 8 PM
5. XYLOCAINE JELLY EVERY 4<sup>th</sup> hrly
6. METROGYL-P OINTMENT L/A THRICE DAILY AT 8AM 2PM 8PM

Review after 7 days in General Surgery OPD.

ARH1.0001231676

**Name**

Mr. L DHAMODHAR

**Patient Identifier** ARHIP55992

**Age** 72Yr  
0Mth  
1Days  
**Date of Admission** 04-Jun-2022

**Sex** Male

**Date of Discharge**  
**MLC No**

**Address** peddapally,Karimnagar,Telangana

**Ward/Bed No** First Floor, HDU, Bed no:HD U 2

**Primary Consultant Surgeons** DR. NIKHIL GOLI --NEUROLOGY

**Consultants**

## PRE-SYNCOPE

History of slip and fall from chair  
Loss of consciousness multiple episodes of vomiting, ENT bleed  
Fever since 1 day

Known case of mentally retarded

## AT ADMISSION:

Afebrile

PR: 80/min

BP: 90/50 mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 97%

P/A: Soft

A 72 years old male patient <sup>Mr. DHAMODHAR</sup> came with history of slip and fall from chair, Loss of consciousness multiple episodes of vomiting, ENT bleed, Fever since 1 day. Known case of mentally retarded. All necessary investigations were done and diagnosed as PRE-SYNCOPE. Managed conservatively. Patient attendants requested for discharge, hence patient is being discharge at request.

DISCHARGE MEDICATION:

-----

1. TAB. ENCORATE CHRONO 500 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS
2. TAB. NEXITO PLUS ONCE **IN A DAY AT 8 PM** FOR 7 DAYS
3. CAP. CARNIK-LC ONCE **IN A DAY AT 8 AM** FOR 7 DAYS

REVIEW AFTER 7 DAYS IN DR NIKHIL GOLI SIR OPD

ARH1.0001231421

<b>Name</b>		Mr. MARAMPELLI NADPIGANGARAM	
<b>Patient Identifier</b>	ARHIP55963	<b>Age</b>	61Yr 4Mth 8Days
<b>Sex</b>	Male	<b>Date of Admission</b>	01-Jun-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	1-75/1, CHINTHAKUNTA,JAGTIAL,Karimnagar,Telangana	<b>Ward/Bed No</b>	First Floor, CICU , Bed no:CICU 4
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE,  
NON ST ELEVATION MYOCARDIAL INFARCTION  
MODERATE LV SYSTOLIC DYSFUNCTION [EF-40%]  
CORONARY ANGIOGRAM (04/06/2022) -CAD-RCA mild disease  
PLAN MEDICAL MANAGEMENT

C/o chest pain, breathlessness since 10 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft



A 61 years old male patient Mr. MARAMPELLI NADPIGANGARAM came with c/o chest pain, breathlessness since 10 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NON ST ELEVATION MYOCARDIAL INFARCTION, MODERATE LV SYSTOLIC DYSFUNCTION [EF-40%], CORONARY ANGIOGRAM (04/06/2022) -CAD-RCA mild disease, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. NOVASTAT 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. BETALOC 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. ANGISPAN TR 2.5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. RAMISTAR 1.25MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001231521

Name

Mr. NILAM RAJU

**Patient Identifier** ARHIP55927

**Age** 27Yr  
4Mth  
5Days

**Sex** Male

**Date of Admission** 30-May-2022

**Date of Discharge**  
**MLC No**

**Address** 2-61, SIRIKONDA,Sircilla,Telangana

**Ward/Bed No** Second Floor, Female General Ward, Bed no:GW 2

**Primary Consultant** Dr. SURESH GOUD S(MS,M

LEFT PROXIMAL URETERIC CALCULUS  
SURGERY : LEFT PUSH BACK PCNL AND DJ STENTING DONE ON 31.05.2022

C/o left loin pain, burning micturition since 10 days

#### AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

All required investigations done and enclosed

A 27 yrs old male patient Mr. NILAM RAJU came to the hospital with c/o left loin pain, burning micturition since 10 days. All necessary investigations done and diagnosed as LEFT PROXIMAL URETERIC CALCULUS, SURGERY : LEFT PUSH BACK PCNL AND DJ STENTING DONE ON 31.05.2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice. Patient explained for stent removal after 3 weeks.

#### DISCHARGE MEDICATION:

-----

1. TAB: ROXSAFE CV 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: FAMOCID 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: NDQ10 ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO UROLOGY OPD, STENT REMOVAL AFTER 3 WEEKS

ARH1.0001106670

Name

Mr. CH NARSAIAH

**Patient Identifier** ARHIP55950

**Age** 61Yr  
11Mth  
29Days

**Sex** Male

**Date of Admission** 31-May-2022

**Date of Discharge**  
**MLC No**

**Address** vegurupally  
manakonduru,Karimnagar,Telangana

**Ward/Bed No** Second  
Floor,  
Female  
General Ward,  
Bed  
no:GW  
3

**Primary Consultant** Dr. SURESH GOUD

LEFT URETERIC CALCULUS

SURGERY: LEFT URSL + DJ STENTING ON 01/06/2022

C/o left loin pain, burning micturition since 1 week.

ON ADMISSION

-----

Patient c/c

Afebrile

PR-92/min

BP-110/70mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft

SPO2-99%

A 61 years old male patient Mr. NARSAIAH presented to hospital with c/o left loin pain, burning micturition since 1 week. All necessary investigations were done and diagnosed as LEFT URETERIC CALCULUS, SURGERY: LEFT URSL + DJ STENTING ON 01/06/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB: ROXSAFE CV 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: FAMOCID 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: NDQ10 ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO UROLOGY OPD, STENT REMOVAL AFTER 3 WEEKS

ARH1.0001231566

**Name**

Mrs. B BAKKAVVA

**Patient Identifier** ARHIP55952

**Age** 41Yr  
0Mth  
4Days

**Sex** Female

**Date of Admission** 01-Jun-2022

**Date of Discharge**  
**MLC No**

**Address** malkapelly, kasheepet,  
mancheryal,Karimnagar,Telangana

**Ward/Bed No** Second  
Floor,  
Female  
General Ward,  
Bed  
no:GW  
5

**Primary Consultant** Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, NSTEMI, NO TLT, SR

NORMAL LV FUNCTION [EF-60%]

CORONARY ANGIOGRAM (01/06/2022) -NORMAL CORONARIES

PLAN MEDICAL MANAGEMENT

R/F : Br. ASTHMA

C/o chest pain a/w SOB since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 41 years old female patient <sup>BAKKAVVA</sup> came with c/o chest pain a/w SOB since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, NO TLT, SF, NORMAL LV FUNCTION [EF-60%], CORONARY ANGIOGRAM (01/06/2022) -CAD-NORMAL CORONARIES, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPIDOGREL 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. CAP. ABFLO 100MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. CAP. AMPOXIN THRICE **IN A DAY AT 8 AM 2PM AND 8 PM** FOR 3 DAYS
6. FOROCORT 200 INHALER 1 puff TWICE DAILY AT 8AM 8PM TO CONTINUE.
7. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001231580

Name

Mr. JANGA HARITHA

**Patient Identifier** ARHIP55960

**Age** 18Yr  
5Mth  
3Days

**Sex** Male

**Date of Admission** 01-Jun-2022

**Date of Discharge**  
**MLC No**

**Address** 2-72/3, GADDAPAKA,Karimnagar,Telangana

**Ward/Bed No** Second Floor, Male General Ward, Bed no:GW 14

**Primary Consultant** Dr. RAMCHANDER TORREM(

## NEPHROTIC SYNDROME

C/o Shortness of breath, bilateral pedal oedema

AT ADMISSION:

Afebrile

PR: 81/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft



A 18 years old male patient Mr. JANGA HARITHA came with c/o shortness of breath, bilateral pedal oedema. All necessary investigations were done and diagnosed as NEPHROTIC SYNDROME. Renal biopsy done under aseptic conditions, procedure was uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB. CEFARAZ-CV TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
2. TAB. DYTOR 10 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. MULTI-8 ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. UBILIFE ONCE DAILY AT 2PM TO CONTINUE.
5. SYP. TUSQ 2 tsp TWICE DAILY AT 8AM AND 8PM

REVIEW AFTER 11 DAYS IN NEPHROLOGY OPD

ARH1.0001231527

**Name**

Mr.  
SUDHEER  
KALLEPALLY

**Patient Identifier**

ARHIP55929

**Age**

40Yr  
0Mth  
5Days

**Sex**

Male

**Date of  
Admission**

30-  
May-  
2022

**Date of Discharge**

**MLC No**

**Address**

1-  
84,paddapalli,karimnagr,Karimnagar,Telangan  
a

**Ward/Bed  
No**

Secon  
d  
Floor,  
Semi  
Private  
, Bed  
no:118  
A

**Primary Consultant**

Dr. RAMCHANDER TORREM

RAPIDLY PROGRESSIVE RENAL FAILURE

DIABETES MELLITUS  
HYPERTENSION

C/o generalized weakness, fever, dysuria and shortness of breath, giddiness since 2 days

AT ADMISSION:

Afebrile

PR: 74/min

BP: 150/110mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 40 years old male patient SUDHEER KALLEPALLY came with c/o generalized weakness, fever, dysuria and shortness of breath, giddiness since 2 days. All necessary investigations were done and diagnosed as RAPIDLY PROGRESSIVE RENAL FAILURE, DIABETES MELLITUS, HYPERTENSION. Renal biopsy done under aseptic conditions, procedure was uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB. CEFARAZ-CV 500 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
2. TAB. DYTOR 10 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. METOZ 5 MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. CARDIVAS 12.5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. CALCI-CZ ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. GEROZ-LP **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS.
7. TAB. MOXOVAS 0.3 MG **THRICE IN A DAY AT 8 AM, 2PM & 8 PM** FOR 7 DAYS.
8. TAB. MINIPRESS-XL **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
9. TAB. PANTOCID 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS.
10. TAB. ZOGER 4 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS.
11. INJ HUMAN MIXTARD 30/70 15 Units AT 8AM 12 Units AT 8PM CONTINUE

REVIEW AFTER 11 DAYS IN NEPHROLOGY OPD

ARH1.0001207837

**Name**

Mr.  
ITIKYALA  
BALAIAH

**Patient Identifier**

ARHIP55930

**Age**

63Yr  
5Mth  
3Days

**Sex**

Male

**Date of Admission**

30-  
May-  
2022

**Date of Discharge**

**MLC No**

**Address**

1-89/1,SHIVAJI  
WADA,RAIKAL,JAGTIAL,Karimnagar,Telangana

**Ward/  
Bed No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:118  
B

**Primary Consultant**

Dr. RAMCHANDER TORREM(MD

AKI

DIABETES MELLITUS  
HYPERTENSION

C/o generalized weakness, fever since 2 days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 140/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 63 years old male patient Mr. ITIKYALA BALAIAH came with c/o generalized weakness, fever since 2 days. All necessary investigations were done and diagnosed as AKI, DIABETES MELLITUS, HYPERTENSION. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB. FAROALFA 200 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS
2. TAB. SOBINIX-DS ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. RECLIDE-XR 30 MG ½ TAB **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. ECOSPRIN 75 MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. STORVAS 40 MG ONCE DAILY AT 8PM TO CONTINUE.
7. TAB. ISOLAZINE 20+375 **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
8. TAB. METOCARD XL 50 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
9. SYP. UROFIT 1 tsp **TWICE IN A DAY AT 8 AM 8 PM**
10. TAB. UBILIFE ONCE DAILY AT 2PM TO CONTINUE.
11. TAB. MULTI-8 ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 11 DAYS IN NEPHROLOGY OPD

ARH1.0001209631

**Name**

Mr. PRANEETH  
KUMAR CH

**Patient  
Identifier**

ARHIP56021

**Age**

31Yr  
1Mth  
6Days

**Sex**

Male

**Date of  
Admission**

06-  
Jun-  
2022

**Date of  
Discharge  
MLC No**

06-Jun-2022

**Address**

VIDYANAGAR,,Karimnagar,Telangana

**Ward/Bed No**

First  
Floor,  
Day  
Care,  
Bed  
no:DC  
3

**Primary  
Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

**Consultants**

**Surgeons**

Dr. Vidya Sagar A--CARDIOLOGY

**Anesthesiologi  
sts**

☐ **Diagnosis**  
S

**Diagnosis**

Disease	Disease Type
---------	--------------

ATYPICAL CHEST PAIN, TMT POSITIVE SR, NORMAL LV SYSTOLIC FUNCTION  
K/C/O SVT,  
R/F SMOKING  
CORONARY AGIOGRAM DONE 6/6/2022 NORMAL CORONARIES (LEFT DOMINANT SYSTEM)  
ADV;MEDICAL MANAGEMENT

C/o palpitations on and off since few days, pain radiating to left arm

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 80/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 31 years old male patient Mr. PRANEETH KUMAR CH came with c/o palpitations on and off since few days, pain radiating to left arm. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN, TMT POSITIVE SR, NORMAL LV SYSTOLIC FUNCTION, K/C/O SVT, R/F SMOKING, CORONARY AGIOGRAM DONE 6/6/2022 NORMAL CORONARIES (LEFT DOMINANT SYSTEM), ADV;MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

#### DISCHARGE MEDICATION:

-----

1. CAP. ECOSPRIN GOLD 10 MG ONCE DAILY AT 8PM TO CONTINUE.
2. TAB. CALAPTIN SR 120 MG ONCE DAILY AT 8AM TO CONTINUE.
3. TAB. NEXPRO 40 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001231202

<b>Name</b>	Mr. LINGAIAH CHILUMULA		
<b>Patient Identifier</b>	ARHIP55867	<b>Age</b>	56Yr 0Mth 16Days
<b>Sex</b>	Male	<b>Date of Admission</b>	25-May-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	15-3-653/1, LBNAGAR,PEDDAPALLI,Telangana	<b>Ward/Bed No</b>	First Floor, CT POST, Bed no:CT 4
<b>Primary Consultant</b>	Dr SOMASHEKAR K(MS,MCH(		

CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + LV DYSFUNCTION+ S/P  
AWMI+DM+HTN, S/P ISR OF RCA & LAD

SURGERY - CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG TO OM, PDA]  
DONE ON 02/06/2022.

C/o retrosternal chest pain a/w sweating since 3 days

K/c/o HTN, T2DM

ON ADMISSION VITAL

-----

Patient conscious, coherent

Afebrile

PR-80/min

BP-110/70mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%



A 56 years old male patient Mr. LINGAIAH CHILUMULA presented to hospital with c/o retrosternal chest pain a/w sweating since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + LV DYSFUNCTION+ S/P AWTMI+DM+HTN, S/P ISR OF RCA & LAD, SURGERY - CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG TO OM, PDA] DONE ON 02/06/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, PARADOXICAL SEPTAL MOTION, MODERATE LV SYSTOLIC FUNCTION, MILD/PR/TR/PAH, EF-34% NO PE/CLOT/VEG.

BMI is 21 kg/m<sup>2</sup>.

Sr. Creatinine report on 03.06.2022 0.8 mg/dl.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. PROLOMET 25 MG TWICE DAILY AT 8AM 8PM BBF TO CONTINUE.
- 4) TAB. THYRONORM 25 MCG ONCE DAILY AT 8AM BBF TO CONTINUE.
- 5) TAB. ND-VIT ONCE DAILY AT 2PM TO CONTINUE.
- 6) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 7) TAB. GLIMESTAR-M4 ONCE DAILY AT 8AM TO CONTINUE.
- 8) TAB. ZITAMET PLUS ONCE DAILY AT 8AM TO CONTINUE.
- 9) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.
- 10) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.
- 11) TAB. DOLO 650MG THRICE DAILY AT 8AM 2PM 8PM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD

ARH1.0001231746		<b>Name</b>	Mr. RAVULA PRAVEEN
<b>Patient Identifier</b>	ARHIP56008	<b>Age</b>	46Yr 0Mth 2Days
<b>Sex</b>	Male	<b>Date of Admission</b>	05-Jun-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	6-41/2,Iqbal ahmed nagar, mancherial,Karimnagar,Telangana	<b>Ward/ Bed No</b>	First Floor, CICU , Bed no:CICU 1
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE INFERIOR WALL MYOCARDIAL INFARCTION

MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%

CORONARY ANGIOGRAM DONE ON 05/06/2022 - CAD-SVD (RCA)

PRIMARY PTCA+DES TO RCA WITH 3.5 X 23 MM XIENCE XPEDITION DONE ON 05/06/2022  
R/F: T2DM

C/o SOB on exertion, chest pain since 5 days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 46 years old male patient Mr. RAVULA PRAVEEN came with c/o SOB on exertion, chest pain since 5 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE INFERIOR WALL MYOCARDIAL INFARCTION, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%, CORONARY ANGIOGRAM DONE ON 05/06/2022 - CAD-SVD (RCA), PRIMARY PTCA+DES TO RCA WITH 3.5 X 23 MM XIENCE XPEDITION DONE ON 05/06/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 75 MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. AX CER 90MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. NOVASTAT 40MG ONCE DAILY AT 8AM TO CONTINUE.
- 4) TAB. VELOZ 20 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. VOGLIVOSE 0.2 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 6) TAB. GLUCORED ½ TAB **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001231792

**Name**

Mrs. MEDAM  
SUNITHA

**Patient  
Identifier**

ARHIP56033

**Age**

39Yr  
0Mth  
1Days

**Sex**

Female

**Date of  
Admission**

07-Jun-  
2022

**Date of  
Discharge  
MLC No**

07-Jun-2022

**Address**

q no : sd-27,nasapur  
colony,,Mancherial,Telangana

**Ward/Bed No**

First  
Floor,  
MICU,  
Bed  
no:MIC  
U 10

**Primary  
Consultant**

DR. SRI KARAN UDDESH --INTERNAL  
MEDICINE

**Consultants**

**Surgeons**

**Anesthesiologi  
sts**

☐ **Diagnosis**  
S

**Diagnosis**

Disease	Disease Type
SEPSIS WITH MODS.	Pd

C/o Shortness of breath since 3 days

Sudden onset of severe hypoxia and restlessness since 1 day treated outside hospital and came here for further management

History of 1 episode of GTCS with the tongue bite

AT ADMISSION:

Patient mechanical ventilator

PR: 86/min

BP: 90/60 mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 100%

P/A: Soft

A 39 years old female patient Mrs. MEDAM SUNITHA came with above mentioned complaints. Patient diagnosed as SEPSIS WITH MODS. Patient treated with Inj Levipil, Inj Piptaz, Inj Vit.K, Inj Albumin, Inj Zofer and Pan, Nebulization. Patient condition improved. Patient is being discharged in hemodynamically stable condition.

ARH1.0001231477

**Patient Identifier** ARHIP55916

**Sex** Female

**Date of Discharge**  
**MLC No**

**Address** H.NO:1-  
82,PEDAGAPALLE,KALWASRIRAMPUR,PEDDAPALLY,Other,Telanga  
na

**Primary Consultant** DR. SANJAY KUMAR KAMINWAR

**Name** Mrs. BHUMAMMA ADIKOPPULA  
**Age** 47Yr 0Mth 10Days  
**Date of Admission** 29-May-2022  
**Ward/Bed No** First Floor, MICU, Bed no:MICU 3

LEFT BASAL GANGLIA BLEED  
OLD LACUNAR INFARCT IN PONS  
OLD POST CRANIOTOMY STATUS (JAN 2020)

C/o weakness of right upper limb and lower limb  
History of left decompressive craniectomy for IC bleed in 2020

AT ADMISSION:

Afebrile

PR: 84/min

BP: 140/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft, BS+

A 47 years old female patient Mrs. BHUMAMMA ADIKOPPULA came with c/o weakness of right upper limb and lower limb, history of left decompressive craniectomy for IC bleed in 2020. All necessary investigations were done and diagnosed as LEFT BASAL GANGLIA BLEED , OLD LACUNAR INFARCT IN PONS, OLD POST CRANIOTOMY STATUS (JAN 2020). Managed conservatively. 2D echo showed RWMA cardiologist consultation taken and advised coronary angiogram later, antiplatelets not given because of bleeding. Neurosurgeon consultation taken and advised followed . Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

- 
- 1) TAB. LEVIPIL 500 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS
  - 2) TAB. TAZLOC 40 MG ONCE DAILY AT 2PM FOR 7 DAYS
  - 3) TAB. TONACT 20 MG ONCE DAILY AT 8PM FOR 7 DAYS
  - 4) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 11 DAYS
  - 5) TAB. DOLO 650 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

REVIEW AFTER 10 DAYS IN DR SANJAY KUMAR SIR OPD

ARH1.0001087117		<b>Name</b> Mr. ANNADI SANJEEVA REDDY	
<b>Patient Identifier</b>	ARHIP55936	<b>Age</b>	80Yr 9Mth 26Days
<b>Sex</b>	Male	<b>Date of Admission</b>	31-May-2022
<b>Expired Date</b>	01-Jun-2022		
<b>MLC No</b>			
<b>Address</b>	SHATHRAJ PALLI,VEMULAWADA,Karimnagar,Telangana		<b>Ward/Bed No</b> First Floor, MICU, Bed no:MIC U 3
<b>Primary Consultant</b>	Dr. RAMCHANDER TORREM(MD (General Medicine),DM Nephrology(NIMS),Consultant Nephrologist)--NEPHROLOGY		<b>Consultants</b>
<b>Surgeons</b>			<b>Anesthesiologists</b>
<b>Diagnosis</b>	<div><div><div>Diagnosis</div><div>S</div></div><div><div>Disease</div><div>Disease Type</div></div></div>		

ACUTE ON CKD, SEPTIC SHOCK

Patient brought to Emergency Room with SOB a/w b/l pedal edema, abdominal distension

AT ADMISSION:

PR: 60/min

BP: 100/60 mmHg

CVS: S1S2

RR: 20/min

SPO2: 94%

P/A: Soft, BS+

A 80 years old male patient Mr. ANNADI SANJEEVA REDDY patient brought to Emergency Room with SOB a/w b/l pedal edema, abdominal distension, Patient was intubated and connected to mechanical ventilator support on SIMV mode with fio2-100%. CPR was initiated as per ACLS protocols, continued for 5 cycles but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 05.51 pm on 31/05/2022.

CAUSE OF DEATH

-----

CARDIOPULMONARY ARREST SECONDARY TO ACUTE ON CKD, SEPTIC SHOCK



ARH1.0001231675

**Name**

**Patient Identifier** ARHIP55989

**Sex** Male

**Date of Discharge**

**MLC No**

**Address** 4-73/8/8/  
C,HANUMANNAGAR,KARIMNAGAR,Karimnagar,Telangana

**Primary Consultant** DR. SANJAY KUMAR KAMINWAR

Mr.  
SAMBIAH  
V

**Age** 72Yr  
0Mth  
5Days

**Date of Admission** 03-Jun-2022

**Ward/Bed No** Second Floor,  
Semi Private,  
Bed no:119B

CVA- ACUTE ISCHAEMIC STROKE

History of giddiness since 4 days, vomiting 1 episode

Known case of hypertension, diabetes mellitus

AT ADMISSION:

Afebrile

PR: 83/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 100%

P/A: Soft

A 72 years old male patient V SAMBAIAH came with c/o giddiness since 4 days, vomiting 1 episode, Known case of hypertension, diabetes mellitus. All necessary investigations were done and diagnosed as CVA- ACUTE ISCHAEMIC STROKE. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

- 1) TAB. PREVA-AS 75 MG ONCE DAILY AT 2PM FOR 5 DAYS
- 2) TAB. COLTRO 10 MG ONCE DAILY AT 2PM FOR 5 DAYS
- 3) TAB. SPINFREE THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS

REVIEW AFTER 7 DAYS IN DR SANJAY KUMAR SIR OPD

ARH1.0001231732

**Name**

Mrs.  
SHAKUNTHALA  
MEDI

**Patient Identifier** ARHIP56003

**Age** 56Yr  
11Mth  
7Days

**Sex** Female

**Date of Admission** 05-Jun-2022

**Date of Discharge**  
**MLC No**

**Address** 4-  
330,LAXMIDEVIPALLE,GANGADHARA,KARIMNAGAR,Karimnagar,Telangan

**Ward/ Bed No** Second Floor,  
Semi Private , Bed no:108  
A

**Primary Consultant** DR. SRI KARAN UDDESH

PROBABLE TRANSIENT ISCHAEMIC ATTACK  
HYPOTHYROIDISM

C/o headache, nausea, transient blurring of vision 2 episodes

Known case of hypothyroidism

AT ADMISSION:

Afebrile

PR: 64/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99% on room air

P/A: Soft

A 56 years old female patient SHAKUNTHALA came with above mentioned complaints. Patient diagnosed as PROBABLE TRANSIENT ISCHAEMIC ATTACK, HYPOTHYROIDISM. Managed conservatively. Neurophysician consultation taken and advice followed. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

- 1) TAB. CLOPILET-A 75/75 MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 3) TAB. CHYMORAL FORTE THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 3 DAYS
- 4) SYP. LACTIFIBER 15 ml TWICE DAILY AT 8AM AND 8PM
- 5) CONTINUE HYPOTHYROID MEDICATION

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

56015

ARH1.0001231756

**Name**

Mrs. VANI  
LAMBU

**Patient Identifier**

ARHIP56015

**Age**

45Yr  
0Mth  
2Days

**Sex**

Female

**Date of  
Admission**

06-Jun-  
2022

**Date of Discharge  
MLC No**

**Address**

VIDYAARANYAPURI, Karimnagar, Telangana

**Ward/  
Bed No**

First  
Floor,  
SICU,  
Bed  
no: SICU  
6

**Primary Consultant**

Dr. GOUTHAM ROY (

EXTERNO-INTERNAL HEMORRHOIDS

SURGERY: OPEN HEMORRHOIDECTOMY DONE ON 07/06/2022

C/o per rectum bleeding, mild constipation since 1 month

PHYSICAL EXAMINATION:

ON ADMISSION

-----

Pt c/c/c

afebrile

PR-82/min

BP-110/70mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

SPO2-100%

A 45 yrs old female patient Mrs. VANI LAMBU came with c/o per rectum bleeding, mild constipation since 1 month. All necessary investigations done and diagnosed as EXTERNO-INTERNAL HEMORRHOIDS

SURGERY: OPEN HEMORRHOIDECTOMY DONE ON 07/06/2022. Findings: External hemorrhoids at 11'O clock and 3'O clock internal haemorrhoids noted. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

#### Discharge Medication:

1. TAB: BECOSULES ONCE DAILY AT 2PM FOR 15 DAYS.
2. TAB: ND Q10 ONCE DAILY AT 2PM FOR 30 DAYS.
3. TAB: ND PAIN **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS.
4. GLUTAVALT -V SACHETS ONCE DAILY AT 8AM WITH GLASS OF WATER FOR 15 DAYS.
5. SYP. LACTIFIBER 3 TSP ONCE IN A DAY AT 8 PM
6. XYLOCAINE JELLY EVERY 4<sup>th</sup> hrly
7. METROGYL-P OINTMENT L/A THRICE DAILY AT 8AM 2PM 8PM
8. SITZ BATH **TWICE IN A DAY AT 8 AM 8 PM**

Review after 7 days in General Surgery OPD.

ARH1.0001231775

<b>Name</b>	Mr. SHREYANSH M		
<b>Patient Identifier</b>	ARHIP56034	<b>Age</b>	6Yr 0Mth 2Days
<b>Sex</b>	Male	<b>Date of Admission</b>	07-Jun-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	13-111,NEAR OLD POST OFFICE,GUEST HOUSE ROAD,DHARMAPURI,Other,Telangana	<b>Ward/ Bed No</b>	Second Floor, Semi Private, Bed no:120A
<b>Primary Consultant</b>	Dr. GOUTHAM ROY (		

PREPEUCAL SKIN TRAUMA WITH LACERATION

SURGERY: CIRCUMCISSION DONE ON 07/06/2022

C/o laceration over the prepuce skin secondary to trauma

PHYSICAL EXAMINATION:

ON ADMISSION

-----

Pt c/c/c

afebrile

PR-90/min

BP-100/60mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

SPO2-98%

A 06 yrs old male <sup>Mr. SHREYANSH</sup> came with c/o laceration over the prepuce skin secondary to trauma. All necessary investigations done and diagnosed as PREPEUCAL SKIN TRAUMA WITH LACERATION, SURGERY: CIRCUMCISSION DONE ON 07/06/2022. Findings: Deep laceration in the prepuce skin. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. SYP. AUGMENTIN 475 MG 5 ml TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
2. SYP. RANTAC 3 ml TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
3. SYP. IBUGESIC PLUS 3 ml TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
4. T-BACT OINTMENT FOR L/A

Review after 7 days in General Surgery OPD.



ARH1.0001231760

		<b>Name</b>	Mr. ARELLI KISTA SWAMY	
<b>Patient Identifier</b>	ARHIP56019	<b>Age</b>	62Yr 0Mth 2Days	
<b>Sex</b>	Male	<b>Date of Admission</b>	06-Jun-2022	
<b>Date of Discharge</b>				
<b>MLC No</b>				
<b>Address</b>	Vittal nagar Godavarikhani,Ramagundam,Telangana		<b>Ward/Bed No</b>	Second Floor, Semi Private , Bed no:123A
<b>Primary Consultant</b>	DR. NIKHIL GOLI --NEUROLOGY			

TYPE II DIABETES MELLITUS  
TRANSIENT ISCHAEMIC ATTACK

History of right sided numbness, paraesthesia since few days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 19/min

SPO2: 98%

P/A: Soft

A 62 years old male patient Mr. ARELLI KISTA SWAMY came with c/o right sided numbness, paraesthesia since few days. All necessary investigations were done and diagnosed as TYPE II DIABETES MELLITUS, TRANSIENT ISCHAEMIC ATTACK. Managed conservatively. General Physician Consultation taken and advice followed. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

- 1) TAB. TONACT-ASP 150 MG ONCE DAILY AT 8PM FOR 7 DAYS
- 2) TAB. TRYCIT PLUS ONCE DAILY AT 8AM FOR 7 DAYS
- 3) TAB. MAXGALIN 75 MG ONCE DAILY AT 8PM FOR 7 DAYS
- 4) TAB. ZORYL MV2 TWICE DAILY AT 8AM AND 8PM TO CONTINUE

REVIEW AFTER 7 DAYS IN DR NIKHIL GOLI SIR OPD

ARH1.0001231687

**Name**

Mr. RAJU K

**Patient Identifier**

ARHIP55999

**Age**

56Yr  
0Mth  
4Days

**Sex**

Male

**Date of Admission**

04-Jun-2022

**Date of Discharge  
MLC No**

**Address**

centenary  
colony, peddapalli, Karimnagar, Telangana

**Ward/  
Bed No**

First  
Floor,  
CICU ,  
Bed  
no: CICU  
1

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, UNSTABLE ANGINA, NO TLT, SR

NORMAL LV SYSTOLIC DYSFUNCTION [EF-60%]

CORONARY ANGIOGRAM (07/06/2022) -CAD-SVD [LAD proximal moderate stenosis]

PLAN MEDICAL MANAGEMENT

R/F : HTN, T2DM

C/o chest pain, radiating to back since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 56 years old male patient K. RAJU came with c/o chest pain, radiating to back since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, NO TLT, SR, NORMAL LV SYSTOLIC DYSFUNCTION [EF-60%], CORONARY ANGIOGRAM (07/06/2022) -CAD-SVD [LAD proximal moderate stenosis], PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

#### DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. DAPAGLYN M 500 MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. COVERSYL 2 MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

.0001227014

<b>Name</b>	Mrs. KOTA ELLAVVA
<b>Patient Identifier</b>	ARHIP55972
<b>Sex</b>	Female
<b>Expired Date</b>	03-Jun-2022
<b>MLC No</b>	
<b>Address</b>	JANNARAM, MANCHERIAL,Mancheria,Telangana
<b>Age</b>	60Yr 4Mth 10Days
<b>Date of Admission</b>	02-Jun-2022
<b>Ward/Bed No</b>	First Floor,

**Primary  
Consultant**  
  
**Surgeons**

Dr Chandra Shekar Sathineni(MD  
(Internal Medicine) )--INTERNAL  
MEDICINE

**Consultants**

**Anesthesiologi  
sts**

Diagnosi  
S

**Diagnosis**

Disease	Disease Type
UREMIC ENCEPHALOPATHY.	Pd

C/o altered sensorium

K/c/o peripheral arterial disease

AT ADMISSION:

PR: 108/min

BP: 90/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 94%

P/A: Soft

A 60 years old female patient Mrs. KOTA ELLAVVA came with c/o altered sensorium, K/c/o peripheral arterial disease . All necessary investigations were done and diagnosed as UREMIC ENCEPHALOPATHY. Poor prognosis explained to the patient attendants, suddenly patient unresponsive. CPR started immediately, INJ. Atropine and INJ. ADRENALINE given emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and inotropic support was given, CPR continued for 40 minutes, according to ACLs guidelines. Patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 10.31 PM on 02/06/2022.

-----

Mr. NASAR

## Anesthesiologists

-

-

Disease	Disease Type
CVA WITH POSTRIOR CIRCULATORY STROKE.	

Patient drowsy

PR: 102/min

BP: 150/100mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

GCS-E4V2M1

A 62 years old male patient <sup>NASAR</sup> came with c/o vomitings, loss of speech. All necessary investigations were done and diagnosed as CVA WITH POSTERIOR CIRCULATORY STROKE. Poor prognosis explained to the patient attendants, patient need to intubate but patient attendants not willing for intubate & ventilator support. On 07/06/2022 at 9.30 AM patient gasping stage, decreased SPO2, brady cardia. CPR started immediately, INJ. Atropine and INJ. ADRENALINE given according to ACLs guidelines. Patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 10.16 AM on 07/06/2022.

## CAUSE OF DEATH

-----

ASPIRATION PNEUMONIA WITH CVA, POSTERIOR CIRCULATORY STROKE.

ARH1.0001231978

**Name**

Mrs. SAROJA T

**Patient Identifier**

ARHIP56102

**Age**

50Yr  
0Mth  
3Days

**Sex**

Female

**Date of Admission**

10-Jun-2022

**Date of Discharge**

12-Jun-2022

**MLC No**

**Address**

RKP,Karimnagar,Telangana

**Ward/Bed No**

First  
Floor,  
MICU,  
Bed  
no:MIC  
U 1

**Primary Consultant**

Dr. KRISHNA CHAITANYA M --

**Consultants**

Surgeons

CARDIOLOGY  
Dr. KRISHNA CHAITANYA M --  
CARDIOLOGY

Anesthesiologists

Diagnosis

Diagnosis

Disease	Disease Type
---------	--------------

CORONARY ARTERY DISEASE-NSTEMI(TROP-I POSITIVE)  
NORMAL LV FUNCTION  
CAG DONE ON 11/06/2022(MINOR CAD)  
PLAN-MEDICAL MANAGEMENT

C/o chest pain and giddiness a/w sweating since 1 day

K/c/o T2DM

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 118/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 50 years old female patient SAROJA came with c/o chest pain and giddiness a/w sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE-NSTEMI(TROP-I POSITIVE), NORMAL LV FUNCTION, CAG DONE ON 11/06/2022(MINOR CAD), PLAN-MEDICAL MANAGEMENT. Patient was treated with antiplatelets, anticoagulation, antacids and other supportive measures. Patient is being



discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN-AV 75/10 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. MET-XL 12.5 MG ONCE DAILY AT 8AM TO CONTINUE.
3. TAB. TELMA-AM 40/5 MG ONCE DAILY AT 8AM TO CONTINUE.
4. TAB. DAPAGY 10MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001010608

<b>Name</b>	Mr. J RAGHUPATHI		
<b>Patient Identifier</b>	ARHIP55993	<b>Age</b>	64Yr 10Mth 9Days
<b>Sex</b>	Male	<b>Date of Admission</b>	04-Jun-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	4-73/8 SARASWATHI NGAR THEEGALAGUTTAPALLI,Karimnagar,Andhra Pradesh	<b>Ward/Bed No</b>	First Floor, CT POST, Bed no:CT 5
<b>Primary Consultant</b>	Dr SOMASHEKAR K(MS,MCH		

CORONARY ARTERY DISEASE, DOUBLE VESSEL DISEASE+DM+HTN+ S/P LUMBAR LAMINECTOMY, +S/P LEFT VARICOSE VEIN SURGERY+THROMBOCYTOPENIA, HYPOTHYROIDISM SURGERY –CORONARY ARTERY BYPASS GRAFTING [SVG TO RI, D1] DONE ON 07/06/2022.

C/o retrosternal chest pain a/w sweating since 1 day

K/c/o T2DM, HTN

ON ADMISSION VITAL

-----

Patient conscious, coherent

Afebrile

PR-80/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 64 years old male patient Mr. RAGHUPATHI presented to hospital with c/o retrosternal chest pain a/w sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, DOUBLE VESSEL DISEASE+DM+HTN+ S/P LUMBAR LAMINECTOMY+S/P LEFT VARICOSE VEIN SURGERY+THROMBOCYTOPENIA, HYPOTHYROIDISM, SURGERY –CORONARY ARTERY BYPASS GRAFTING [SVG TO RI, D1] DONE ON 07/06/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, CONCENTRIC LVH, NORMAL LV SYSTOLIC FUNCTION, GRADE-I DIASTOLIC DYSFUNCTION, NO PE/CLOT/VEG

BMI is 24.8 kg/m<sup>2</sup>.

Sr. Creatinine report on 07.06.2022 1.2 mg/dl.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. ND-VIT ONCE DAILY AT 2PM TO CONTINUE.
- 4) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. THYRONORM 25 MCG ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.
- 7) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.
- 8) TAB. TRAMADOL 50MG THRICE DAILY AT 8AM 2PM 8PM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD WITH TSH REPORT

ARH1.0001225175

**Name**

Mr. M  
SANJEEV

**Patient Identifier**

ARHIP56077

**Age**

29Yr  
8Mth  
4Day  
s

**Sex**

Male

**Date of  
Admission**

09-  
Jun-  
2022

**Date of Discharge**

**MLC No**

**Address**

3-94 KAMMARI WADA RUDRAVARAM  
VEMULAWADA ,Sircilla,Telangana

ACUTE GASTROENTERITIS  
HYPOTENSION  
RHABDOMYOLYSIS

C/o fever, loose motion, vomiting since 1 day multiple episodes

History of CKD on MHD last on 07/06/2022

AT ADMISSION:

Afebrile

PR: 80/min

BP: 90/60 mmHg

RS: BAE+

CVS: S1S2

RR: 19/min

SPO2: 98%

A 29 years old male patient Mr. M SANJEEV came with c/o fever, loose motion, vomiting since 1 day multiple episodes. All necessary investigations were done and diagnosed as ACUTE GASTROENTERITIS, HYPOTENSION, RHABDOMYOLYSIS. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.  
DISCHARGE MEDICATION:

-----

1. TAB. FEBUGET 40 MG ONCE DAILY AT 8AM TO CONTINUE.
2. TAB. GEROZ-LP THRICE DAILY AT 8AM 2PM 8PM FOR 7 DAYS.
3. TAB. MULTI-8 ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. UBILIFE ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. NICARDIA RETARD 20 MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
6. TAB. PRAXORIL 5 MG TWICE DAILY AT 9AM 9PM TO CONTINUE.

REVIEW AFTER 7 DAYS IN NEPHROLOGY OPD

ARH1.0001226340

**Name**

Mr. AKKALA  
THIRUPATHI

**Patient Identifier**

ARHIP56101

**Age**

41Yr  
5Mth  
6Days

**Sex**

Male

**Date of  
Admission**

10-  
Jun-  
2022

**Date of Discharge  
MLC No**

**Address**

CHINTAPALLE  
ADILABAD ,Nirmal,Telangana

**Ward/Bed  
No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:108  
B

**Primary Consultant**

Dr. SURESH GOUD S(

RIGHT URETERIC CALCULUS

SURGERY: RIGHT URSL + DJ STENTING ON 11/06/2022

C/o abdominal pain since 1 day.

ON ADMISSION

-----

Patient c/c

Afebrile

PR-90/min

BP-110/70mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft

SPO2-98%

A 41 years old male patient Mr. AKKALA THIRUPATHI presented to hospital with c/o abdominal pain since 1 day. All necessary investigations were done and diagnosed as RIGHT URETERIC CALCULUS, SURGERY: RIGHT URSL + DJ STENTING ON 11/06/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB: ROXSAFE CV 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: PAN-D ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: NDQ10 ONCE DAILY AT 2PM FOR 11 DAYS
5. TAB: URIMAX 0.4 MG ONCE DAILY AT 8PM FOR 7 DAYS
6. SYP. K-CIT 10 ML THRICE DAILY AT 8AM 2PM & 8 P.M.

REVIEW AFTER 7 DAYS TO UROLOGY OPD.

REVIEW AFTER 3 WEEKS FOR DJ STENT REMOVAL.

ARH1.0001159170

**Name**

Mr. SHAIK  
KAREEMUDDIN

**Patient  
Identifier**

ARHIP55961

**Age**

43Yr  
1Mth  
25Days

**Sex**

Male

**Date of  
Admission**

01-  
Jun-  
2022

**Date of  
Discharge  
MLC No**

**Address**

6-3-125, NEAR  
MASJID KHANPURA, Karimnagar, Telangana

**Ward/  
Bed No**

First  
Floor,  
CT  
POST,  
Bed  
no: CT  
6

**Primary  
Consultant**

Dr SOMASHEKAR K(MS,

SEVERE CALCIFIC AORTIC STENOSIS WITH SEVERE LV DYSFUNCTION [EF-30%] WITH PSYCHIATRIC ILLNESS- BIPOLAR DISORDER, CERVICAL SPONDYLOSIS

**Surgery:** AORTIC VALVE REPLACEMENT WITH TTKC NO 21 MM MECHANICAL VALVE DONE ON 08/06/2022

C/o SOB on exertion a/w palpitations since 3 days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%



P/A: Soft

A 43 years old male patient Mr. SHAIK KAREEMUDDIN came with c/o SOB on exertion a/w palpitations since 3 days. All necessary investigations were done and diagnosed as SEVERE CALCIFIC AORTIC STENOSIS WITH SEVERE LV DYSFUNCTION [EF-30%] WITH PSYCHIATRIC ILLNESS- BIPOLAR DISORDER, CERVICAL SPONDYLOSIS, **Surgery:** AORTIC VALVE REPLACEMENT WITH TTKC NO 21 MM MECHANICAL VALVE DONE ON 08/06/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, he is being discharged with required medication and advice.

POST AVR 2D ECHO REPORTS SHOWED POST MVR STATUS , PROSTHETIC VALVE INSITU, NO VALVULAR/ PARAVALVULAR LEAK, CONCENTRIC LVH, MODERATE LV DYSFUNCTION. NO CLOT/PE/VEG

BMI is 22 kg/m<sup>2</sup>.

Sr. Creatinine report done on 09.06.2022 1.3 mg/dl

DISCHARGE MEDICATION:

-----

- 1) TAB. ACITROM 1 MG & 2 MG ALTERNATE DAY AT 7PM TO CONTINUE FOR LIFE LONG.
- 2) TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. ND VIT ONCE DAILY AT 2 PM TO CONTINUE
- 4) TAB. PROLOMET-XL 25 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. ARIPIRAZOLE 5 MG ONCE DAILY AT 8PM TO CONTINUE.
- 6) TAB. DRAZEP 2TAB ONCE DAILY AT 8PM TO CONTINUE.
- 7) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.
- 8) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.
- 9) TAB. TRAMADOL 50MG THRICE DAILY AT 8AM 2PM 8PM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD

ARH1.0001231852		<b>Name</b>	Mr. PRAVEENKUMAR GANKIDI
<b>Patient Identifier</b>	ARHIP56070	<b>Age</b>	34Yr 0Mth 5Days
<b>Sex</b>	Male	<b>Date of Admission</b>	08-Jun-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	NARSAPUR,Nirmal,Telangan a	<b>Ward/Bed No</b>	Second Floor, Male Genera l Ward, Bed no:GW 21
<b>Primary Consultant</b>	Dr. SURESH GOUD S		

RIGHT PROXIMAL URETERIC CALCULUS  
RIGHT PUSH BACK PCNL + DJ STENTING DONE ON 09.06.2022

C/o Right loin pain, burning micturition since 10 days

#### AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

All required investigations done and enclosed

A 34 yrs old male patient Mr. PRAVEENKUMAR GANKIDI came to the hospital with c/o right loin pain, burning micturition since 10 days. All necessary investigations done and diagnosed as RIGHT PROXIMAL URETERIC CALCULUS, RIGHT PUSH BACK PCNL + DJ STENTING DONE ON 09.06.2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice. Patient explained for stent removal after 3 weeks.

DISCHARGE MEDICATION:

-----

1. TAB: ROXSAFE CV 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: PAN 40MG ONCE DAILY AT 7AM BBF FOR 10 DAYS.
4. TAB: NDQ10 ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO UROLOGY OPD, STENT REMOVAL AFTER 3 WEEKS

ARH1.0001231803		<b>Name</b>	Ms. SHOBHA RANI K
<b>Patient Identifier</b>	ARHIP56035	<b>Age</b>	56Yr 0Mth 6Days
<b>Sex</b>	Female	<b>Date of Admission</b>	07-Jun-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	FLAT NO:308, KAILASA RESIDENCY, OPP APOLLO REACH HOSPITAL,Karimnagar,Telangana	<b>Ward/ Bed No</b>	First Floor, CICU , Bed no:CICU12
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE ANTERIOR WALL MYOCARDIAL INFARCTION

MILD LV SYSTOLIC DYSFUNCTION, EF-44%

CORONARY ANGIOGRAM DONE ON 07/06/2022 - CAD-SVD (LAD)

PRIMARY PTCA+DES TO LAD WITH 3.5 X 13 MM PRONOVA DONE ON 07/06/2022  
ESBL, E,COLI, URINARY TRACT INFECTION

C/o chest pain, fever, burning micturition since 2 days

AT ADMISSION:

PR: 109/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 96% on room air

P/A: Soft

A 56 years old female patient Ms. SHOBHA RANI K came with c/o chest pain, fever, burning micturition since 2 days . All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE ANTERIOR WALL MYOCARDIAL INFARCTION, MILD LV SYSTOLIC DYSFUNCTION, EF-44%, CORONARY ANGIOGRAM DONE ON 07/06/2022 – CAD-SVD (LAD), PRIMARY PTCA+DES TO LAD WITH 3.5 X 13 MM PRONOVA [LOT NO: 5211889, S/N :05060127249091] DONE ON 07/06/2022, ESBL, E,COLI, URINARY TRACT INFECTION. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPITAB 75 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. CILODOC 50MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 4) TAB. NOVASTAT 40MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS
- 6) TAB. FAROPENUM 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.





ARH1.0001231985

**Name**

Mr. BHOOMAIAH  
THADAKAPALLY

**Patient  
Identifier**

ARHIP56114

**Age**

53Yr  
0Mth  
3Days

**Sex**

Male

**Date of  
Admission**

10-Jun-  
2022

**Date of  
Discharge  
MLC No**

**Address**

somarampet,rajanna  
sircilla,Karimnagar,Telangana

**Ward/  
Bed No**

First  
Floor,  
HDU,  
Bed  
no:HD  
U 5

**Primary  
Consultant**

Dr. KRISHNA CHAITANYA M --  
CARDIOLOGY

S

CORONARY ARTERY DISEASE, AWSTEMI

SEVERE LV DYSFUNCTION, EF-40%

R/F: CHRONIC SMOKER

CORONARY ANGIOGRAM DONE ON 10/06/2022 - CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.5 X 19 MM METAFOR DONE ON 10/06/2022

C/o Retrosternal chest pain, sweating since 2 days

AT ADMISSION:

Afebrile

PR: 97/min

BP: 100/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 95% on room air

P/A: Soft

A 53years old male patient Mr. BHOOAIAH THADAKAPALLY came with c/o retrosternal chest pain, sweating since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWSTEMI, SEVERE LV DYSFUNCTION, EF-40%, R/F: CHRONIC SMOKER, CORONARY ANGIOGRAM DONE ON 10/06/2022 – CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.5 X 19 MM METAFOR [LOT NO: MH23, S/N CM19MH23041]. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPIDOGREL 75MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. ATORVA 40MG ONCE DAILY AT 8AM TO CONTINUE.
- 4) TAB. FRUSELAC DS 40/25 ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. MET-XL 25 MG ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. RAMISTAR 2.5 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH CBC, RP-II REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001218781

**Name**

Mrs.  
CHANDRAMM  
A J

**Patient Identifier**

ARHIP55943

**Age**

60Yr  
10Mth  
9Days

**Sex**

Female

**Date of  
Admission**

31-  
May-  
2022

**Date of Discharge  
MLC No**

**Address**

GATTUDUDDENAPALLY,Karimnagar,Telang  
ana

**Ward/Bed  
No**

Secon  
d  
Floor,  
Semi  
Private  
, Bed  
no:103  
A

**Primary Consultant**

Dr. RAMCHANDER TORRE

ACUTE ON CHRONIC KIDNEY DISEASE

C/o Shortness of breath associated with fever

Known case of CKD, Hypertension & Diabetes mellitus

AT ADMISSION:

PR: 81/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

A 60 years old female patient CHANDRAMMA came with c/o shortness of breath associated with fever. All necessary investigations were done and diagnosed as ACUTE ON CHRONIC KIDNEY DISEASE. Managed conservatively. 1 unit RBC transfusion given. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. FAROALFA 200 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
2. TAB. CILACAR M 10/50 **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. SOBINIX DS ONCE DAILY AT 8AM AND 8PM TO CONTINUE.
4. TAB. ESOCLOCK DSR 40 MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. KETO CHECK THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS
6. TAB. THYRONORM 25 MCG ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. CUDCE FORT THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS
8. SYP. GRILLINCTUS 1 tsp THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS
9. TAB. UBILIFE ONCE DAILY AT 2PM TO CONTINUE.
10. TAB. MULTI-8 ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 5 DAYS IN NEPHROLOGY OPD



ARH1.0001206329

<b>Name</b>	Mr. POREDDY MALLA REDDY		
<b>Patient Identifier</b>	ARHIP56110	<b>Age</b>	65Yr 3Mth 0Days
<b>Sex</b>	Male	<b>Date of Admission</b>	10-Jun-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	10-4-291/1/D, VAVILALAPALLI,Karimnagar,Telangana	<b>Ward/Bed No</b>	Second Floor, Semi Private , Bed no:122A
<b>Primary Consultant</b>	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)-- GENERAL SURGERY		

CHRONIC CALCULUS CHOLECYSTITIS  
SURGERY: LAPROSCOPIC CHOLECYSTECTOMY DONE ON 06.05.2022

C/o pain abdomen on and off since few days

#### PHYSICAL EXAMINATION:

#### ON ADMISSION

-----

Pt c/c/c

afebrile

PR-82/min

BP-120/80mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 65 yr old male patient Mr. POREDDY MALLA REDDY came with c/o pain abdomen on and off since few days. All necessary investigations done and diagnosed as CHRONIC CALCULUS CHOLECYSTITIS, SURGERY: LAPROSCOPIC CHOLECYSTECTOMY DONE ON 06.05.2022. Findings: Few omental adhesions with thickened gallbladder wall and inflammatory changes, short cystic duct. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. TAB: SOMPRAZ-L TWICE DAILY AT 8AM, 8PM FOR 15 DAYS
5. GLUTAVAUULT -V SACHETS ONCE DAILY AT 8AM WITH GLASS OF WATER FOR 15 DAYS.

Review after 7 days in General Surgery OPD.



ARH1.0001231817

**Name**

Mr. EDLA  
BANAIAH

**Patient Identifier**

ARHIP56044

**Age**

66Yr  
0Mth  
6Days

**Sex**

Male

**Date of  
Admission**

07-Jun-  
2022

**Date of Discharge  
MLC No**

**Address**

CCC, SRIRAMPUR, Mahabubabad, Telangana

**Ward/  
Bed No**

Second  
Floor,  
Semi  
Private,  
Bed  
no:120  
A

**Primary Consultant**

Dr. GOUTHAM ROY (MS

RIGHT INGUINAL INDIRECT COMPLETE HERNIA WITH HYDROCELE

SURGERY : OPEN RIGHT INGUINAL HERNIOTOMY+HYDROCELECTOMY DONE ON 11.06.2022

C/o swelling in right groin region

PHYSICAL EXAMINATION:

ON ADMISSION

-----

Pt c/c/c

afebrile

PR-80/min

BP-120/80mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 66 yr old male patient EDLA BANAI AH came with c/o swelling in right groin region. All necessary investigations done and diagnosed as RIGHT INGUINAL INDIRECT COMPLETE HERNIA WITH HYDROCELE,

SURGERY : OPEN RIGHT INGUINAL HERNIOTOMY+HYDROCELECTOMY DONE ON 11.06.2022.

Findings: Long studing sac with moderate right hydrocele , indirect defect with bowel loops as its contents. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

#### DISCHARGE MEDICATION:

1. TAB: ROXSAFE-CV TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. TAB: ROTAVAUULT THRICE IN A DAY AT 8 AM 2 PM & 8 PM FOR 15 DAYS.
5. TAB: ZERODOL SP TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
6. GLUTAVAUULT SACHETS ONCE DAILY AT 8AM WITH GLASS OF WATER FOR 15 DAYS.
7. SCROTAL SUPPORT

Review after 10 days in General Surgery OPD.

ARH1.0001231882

**Name**

Mr. MD ZAHEED

**Patient Identifier**

ARHIP56075

**Age**

62Yr  
0Mth  
5Days

**Sex**

Male

**Date of Admission**

09-Jun-2022

**Date of Discharge  
MLC No**

**Address**

JAGITIAL,Karimnagar,Telangana

**Ward/  
Bed No**

Second  
Floor,  
Semi  
Private,  
Bed  
no:110  
A

**Primary Consultant**

Dr. RAMCHANDER TORREM

AKI,  
DIABETES MELLITUS  
HYPERTENSION

C/o Shortness of breath associated with fever since 1 day

Known case of HTN, T2DM

AT ADMISSION:

PR: 94/min

BP: 160/100mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

A 62 years old male patient MD ZAHEED came with c/o shortness of breath associated with fever since 1 day . All necessary investigations were done and diagnosed as AKI, DIABETES MELLITUS, HYPERTENSION. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. CLOCEF-CV 620 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
2. TAB. CILACAR M 10/50 **ONCE IN A DAY AT 2 PM** TO CONTINUE.
3. TAB. SOBINIX DS **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. CUDCE THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS
5. TAB. KETO CHECK THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS
6. TAB. ROZAGOLD ONCE DAILY AT 2PM TO CONTINUE.
7. TAB. VELTAM 0.4 MG ONCE DAILY AT 2PM TO CONTINUE.
8. TAB. DYTOR 10 MG **ONCE IN A DAY AT 2 PM** TO CONTINUE.

REVIEW AFTER 7 DAYS IN NEPHROLOGY OPD

ARH1.0001231843

**Name**

Mr. M MALLAIAH

**Patient Identifier**

ARHIP56073

**Age**

68Yr  
0Mth  
5Days

**Sex**

Male

**Date of Admission**

09-Jun-2022

**Date of Discharge  
MLC No**

**Address**

KELLEDU,Karimnagar,Telangana

**Ward/  
Bed No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:120  
B

**Primary Consultant**

Dr. RAMCHANDER TORREM

## ACUTE KIDNEY INJURY

C/o shortness of breath on and off since a few days,  
abdominal distension and bloating of stomach since few days

### AT ADMISSION:

Afebrile

PR: 79/min

BP: 90/50mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 95%

P/A: Soft

A 68 years old male patient MALLAIAH came with c/o shortness of breath on and off since a few days, abdominal distension and bloating of stomach since few days. All necessary investigations were done and diagnosed as ACUTE KIDNEY INJURY. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. CEFURAZ-CV **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
2. TAB. SOBINIX DS **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. CILACAR M 10 MG **ONCE IN A DAY AT 2 PM** TO CONTINUE.
4. TAB. VELTAM 0.4 MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. ROSAGOLD ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. CUDCE THrice IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS
7. TAB. KETO CHECK THrice IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS
8. TAB. MULTI-8 **ONCE IN A DAY AT 2 PM** TO CONTINUE.
9. TAB. UBILIFE **ONCE IN A DAY AT 2 PM** TO CONTINUE.
10. TAB. ULTRACET **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS

REVIEW AFTER 7 DAYS IN NEPHROLOGY OPD

ARH1.0001231933

**Name**

Mr. M RAJU

**Patient Identifier**

ARHIP56087

**Age**

50Yr  
0Mth  
4Days

**Sex**

Male

**Date of Admission**

09-Jun-2022

**Date of Discharge  
MLC No**

**Address**

1-  
11,katkoor,siddipet,Siddipet,Telangana

**Ward/  
Bed No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:123  
B

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

ATYPICAL CHEST PAIN, SR

NORMAL LV FUNCTION [EF-65%]

CORONARY ANGIOGRAM (11/06/2022) -NORMAL CORONARIES

PLAN MEDICAL MANAGEMENT

C/o chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 50 years old male patient M RAJU came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN, SR , NORMAL LV FUNCTION [EF-65%], CORONARY ANGIOGRAM (11/06/2022) -NORMAL CORONARIES, PLAN MEDICAL MANAGEMENT. Patient is being discharged at request.

DISCHARGE MEDICATION:

-----

1. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. ATORVA 20MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 11 DAYS.
4. TAB. ACTON OR TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD





ARH1.0001231822

**Name**

Mr.  
LACHAIAH  
SHIVARATHRI

**Patient Identifier**

ARHIP56049

**Age**

38Yr  
0Mth  
6Days

**Sex**

Male

**Date of Admission**

07-Jun-  
2022

**Date of Discharge**

**MLC No**

**Address**

NAMAPALLI, RAJANNA  
SIRICILLA, Karimnagar, Telangana

**Ward/Bed No**

Second  
Floor,  
Male  
General Ward,  
Bed  
no:GW  
20

**Primary Consultant**

Dr. SURESH GOUD S(MS,M.Ch

LEFT RENAL CALCULUS  
SURGERY : LEFT PCNL + DJ STENTING DONE ON 09.06.2022

C/o left loin pain, burning micturition since 10 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

All required investigations done and enclosed

A 38 yrs old male patient Mr. LACHAIAH SHIVARATHRI came to the hospital with c/o left loin pain, burning micturition since 10 days. All necessary investigations done and diagnosed as LEFT RENAL CALCULUS, SURGERY : LEFT PCNL + DJ STENTING DONE ON 09.06.2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice. Patient explained for stent removal after 3 weeks.

#### DISCHARGE MEDICATION:

-----

1. TAB: ROXSAFE CV 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: FAMOCID 40MG ONCE DAILY AT 7AM BBF FOR 11DAYS.
4. TAB: NDQ10 ONCE DAILY AT 2PM FOR 11 DAYS

REVIEW AFTER 11 DAYS TO UROLOGY OPD, STENT REMOVAL AFTER 3 WEEKS

ARH1.0001231884

<b>Name</b>	Mr. RAMULU KAVAMPELLI		
<b>Patient Identifier</b>	ARHIP56072	<b>Age</b>	43Yr 0Mth 5Days
<b>Sex</b>	Male	<b>Date of Admission</b>	09-Jun-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	2-91 DUNDERPALLI, Karimnagar, Telangana	<b>Ward/ Bed No</b>	First Floor, RECOVERY ROOM, Bed no:RR 10
<b>Primary Consultant</b>	Dr. Iftekarali (MS (Orthopaedics		

CLOSED COMMUNUTED SEGMENTAL FRACTURE SHAFT TIBIA LEFT

SURGERY: LEFT INTERLOCKING TIBIA + FIBULA RUSH NAILING+FASCIOTOMY DONE ON 09/10/2022

Alleged to have sustained injury due to fall from Bullcort while get down himself on 08/06/22 around 8:30 p.m. at work place, sustained injury to left leg

PHYSICAL EXAMINATION:

ON ADMISSION

-----  
afebrile  
PR-84/min  
BP-120/80mmhg  
RR-20/min  
RS-BAE+  
CVS-S1S2+  
P/A-Soft  
SPO2-99%

A 43 years old male patient Mr. RAMULU KAVAMPELLI came with alleged to have sustained injury due to fall from Bullcort while get down himself on 08/06/22 around 8:30 p.m. at work place, sustained injury to left leg . All necessary investigations were done and diagnosed as CLOSED COMMUNUTED SEGMENTAL FRACTURE SHAFT TIBIA LEFT, SURGERY: LEFT INTERLOCKING TIBIA + FIBULA RUSH NAILING+FASCIOTOMY DONE ON 09/10/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence she is being discharged with required medication and advice.

DISCHARGE MEDICATION:

- 
1. TAB. TROUFIZ 500MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
  2. TAB. VOVERAN SR TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
  3. TAB. DISENCHER TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
  4. TAB. RANTAC 150 MG ONCE DAILY AT 8AM FOR 11 DAYS.

REVIEW AFTER 11 DAYS TO DR. IFTEKARALI SIR OPD.

ARH1.0001230960

<b>Name</b>	Mr. VADAKAPURAM DAMODARA CHARY		
<b>Patient Identifier</b>	ARHIP56067	<b>Age</b>	57Yr 0Mth 28Days
<b>Sex</b>	Male	<b>Date of Admission</b>	08-Jun-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	Alugunur,Karimnagar,Telangana	<b>Ward/ Bed No</b>	Second Floor, Male General Ward, Bed no:GW17
<b>Primary Consultant</b>	Dr. SURESH GOUD		

LEFT URETERIC CALCULUS

SURGERY: LEFT URSL + DJ STENTING DONE ON 09/06/2022

C/o left loin pain, burning micturition since 1 week.

ON ADMISSION

-----

Patient c/c

Afebrile

PR-80/min

BP-110/70mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft

SPO2-99%

A 57 years old male patient Mr. VADAKAPURAM DAMODARA CHARY presented to hospital with c/o left loin pain, burning micturition since 1 week. All necessary investigations were done and diagnosed as LEFT URETERIC CALCULUS, SURGERY: LEFT URSL + DJ STENTING DONE ON 09/06/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB: ROXSAFE CV 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: FAMOCID 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: NDQ10 ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO UROLOGY OPD.

REVIEW AFTER 3 WEEKS FOR DJ STENT REMOVAL.

ARH1.0001231828

<b>Name</b>		Mr. BHOOMAIAH CHIKKULA	
<b>Patient Identifier</b>	ARHIP56052	<b>Age</b>	67Yr 0Mth 6Days
<b>Sex</b>	Male	<b>Date of Admission</b>	08-Jun-2022
<b>Date of Discharge MLC No</b>			
<b>Address</b>	4-3-82 BEET BAZAR,Karimnagar,Telangana	<b>Ward/ Bed No</b>	Second Floor, Female General Ward, Bed no:GW 11
<b>Primary Consultant</b>	Dr. RAMCHANDER TORREM		

AKI,  
DIABETES MELLITUS  
HYPERTENSION

C/o sudden profuse sweating, vertigo, mild SOB since 1 day

Known case of HTN, T2DM,  
H/o PTCA 2017

AT ADMISSION:

PR: 84/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%



A 67 years old male patient Mr. BHOOMIAH CHIKKULA came with c/o sudden profuse sweating, vertigo, mild SOB since 1 day . All necessary investigations were done and diagnosed as AKI, DIABETES MELLITUS, HYPERTENSION. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. CLOCEF-CV 620 MG **TWICE IN A DAY AT 8 AM 8 PM**TO CONTINUE.
2. TAB. SOBINIX DS **TWICE IN A DAY AT 8 AM 8 PM**TO CONTINUE.
3. TAB. KETOCHECK THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS
4. TAB. CUDCE THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS
5. TAB. RECLIDE MR ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. CARDIVAS 6.25 MG **TWICE IN A DAY AT 8 AM 8 PM**TO CONTINUE.
7. TAB. ECOSPRIN 150 MG **ONCE IN A DAY AT 2 PM**TO CONTINUE.
8. TAB. CLOPILET 75 MG **ONCE IN A DAY AT 2 PM**TO CONTINUE.
9. TAB. AZTOR 40 MG **ONCE IN A DAY AT 2 PM**TO CONTINUE.
- 10.TAB. FEFOQ-8 **ONCE IN A DAY AT 2 PM**TO CONTINUE.
- 11.TAB. MULTI-8 **ONCE IN A DAY AT 2 PM**TO CONTINUE.

REVIEW AFTER 11 DAYS IN NEPHROLOGY OPD

ARH1.0001231868

**Name**

Mr. AKULA RAMA  
SWAMI

**Patient  
Identifier**

ARHIP56064

**Age**

60Yr  
0Mth  
5Days

**Sex**

Male

**Date of  
Admission**

08-Jun-  
2022

**Date of  
Discharge  
MLC No**

**Address**

MANAKONDUR,Karimnagar,Telangana

**Ward/  
Bed No**

Second  
Floor,  
Male  
General  
Ward,  
Bed  
no:GW  
22

**Primary  
Consultant**

DR. SUBRAT KUMAR SOREN --  
NEUROSURGERY

RTA, TRAUMATIC BRAIN INJURY  
ACUTE THIN SDH ON LEFT TEMPORAL REGION  
ACUTE HAEMATOMA LEFT TEMPORAL LOBE

Alleged h/o sustained injury due to RTA, slip and fall from 2 wheeler himself  
history of LOC and vomitings+

AT ADMISSION:

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 60 years old male patient Mr. AKULA RAMA SWAMI came with alleged h/o sustained injury due to RTA, slip and fall from 2 wheeler himself, history of LOC and vomitings+. All necessary investigations were done and diagnosed as RTA, TRAUMATIC BRAIN INJURY, ACUTE THIN SDH ON LEFT TEMPORAL REGION , ACUTE HAEMATOMA LEFT TEMPORAL LOBE. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

- 1) TAB. LEVIPIL 500 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS
- 2) TAB. LIBRIUM 20 MG ONCE DAILY AT 8PM FOR 10 DAYS
- 3) TAB. DOLO 650 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 4) TAB. THIAMINE 100 MG ONCE DAILY AT 2PM FOR 10 DAYS
- 5) TAB. ND Q10 ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 11 DAYS IN NEUROSURGERY OPD

ARH1.0001231790

		<b>Name</b>	Mrs. KANAKAM VENKATAMMA	
<b>Patient Identifier</b>	ARHIP56032	<b>Age</b>	65Yr 0Mth 7Days	
<b>Sex</b>	Female	<b>Date of Admission</b>	07-Jun-2022	
<b>Date of Discharge</b>				
<b>MLC No</b>				
<b>Address</b>	H.NO:70,MUTHARAM,KARIMNAGAR,Telangana		<b>Ward/Bed No</b>	Second Floor, Female General Ward, Bed no:GW 4
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, NSTEMI

MILD LV DYSFUNCTION, EF-45%

R/F: ALCOHOLIC

CORONARY ANGIOGRAM DONE ON 09/06/2022 - CAD-DVD (LAD, LCX)

PTCA+DES TO LAD WITH 2.5 X 37 MM METAFOR DONE ON 09/06/2022  
PLAN MEDICAL MANAGEMENT FOR LCX [CTO]

C/o sudden onset of chest pain 1 day

AT ADMISSION:

Afebrile

PR: 84/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 65years old male patient Mrs. KANAKAM VENKATAMMA came with c/o sudden onset of chest pain 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, MILD LV DYSFUNCTION, EF-45%, R/F: ALCOHOLIC, CORONARY ANGIOGRAM DONE ON 09/06/2022 - CAD-DVD (LAD, LCX), PTCA+DES TO LAD WITH 2.5 X 37 MM METAFOR DONE ON 09/06/2022, PLAN MEDICAL MANAGEMENT FOR LCX [CTO]. Neurophysician consultation taken and advice followed. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. CILODOC 50 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 4) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. PROLOMET XL 25 MG ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. RAMISTAR 2.5 MG ONCE DAILY AT 8AM TO CONTINUE.
- 7) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS
- 8) TAB. GLYCOMET SR 500 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001185936

**Name**

Mrs.  
ANKAM  
SAROJANA

**Patient Identifier**

ARHIP55991

**Age**

48Yr  
10Mth  
24Days

**Sex**

Female

**Date of Admission**

04-Jun-2022

**Date of Discharge  
MLC No**

**Address**

17-23/  
A,MANTHANI,PEDDAPALLI,Karimnagar,Telangana

**Ward/  
Bed No**

First  
Floor,  
CT  
POST,  
Bed  
no:CT  
2

**Primary Consultant**

Dr SOMASHEKAR K(MS,MCH(CTVS

CRHD WITH SEVERE MS WITH PAH, HYPOTHYROIDISM

Surgery: MITRAL VALVE REPLACEMENT WITH TTKC NO. 29 mm, MECHANICAL VALVE  
DONE ON 09/06/2022

C/o SOB on exertion a/w palpitations since 3 days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 48 years old female patient Mrs. ANKAM SAROJANA came with c/o SOB on exertion a/w palpitations since 3 days. All necessary investigations were done and diagnosed as CRHD WITH SEVERE MS WITH PAH, HYPOTHYROIDISM, Surgery: MITRAL VALVE REPLACEMENT WITH TTKC NO. 29 mm, MECHANICAL VALVE DONE ON 09/06/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, he is being discharged with required medication and advice.

POST MVR 2D ECHO REPORTS SHOWED POST MVR STATUS , PROSTHETIC VALVE INSITU, NO VALVULAR/ PARAVALVULAR LEAK, NORMAL LV FUNCTION. NO CLOT/PE/VEG, [EF-60%]

BMI is 12.7 kg/m<sup>2</sup>.

Sr. Creatinine report done on 10.06.2022 0.8 mg/dl

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ACITROM 1 MG ONCE DAILY AT 7PM TO CONTINUE FOR LIFE LONG.
- 2) TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. ELTROXIN 50 MCG ONCE DAILY AT 8AM TO CONTINUE.
- 4) TAB. ND VIT ONCE DAILY AT 2 PM TO CONTINUE
- 5) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.
- 6) TAB. TRAMADOL 50MG THRICE DAILY AT 8AM, 2PM AND 8PM FOR 5 DAYS.
- 7) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.
- 8) TAB. ALPRAX 0.25 MG ONCE DAILY AT 8PM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD WITH PT-INR REPORTS



ARH1.0001231874

**Name**

Mrs. J  
SUSHEELA

**Patient Identifier**

ARHIP56065

**Age** 68Yr 0Mth  
6Days

**Sex**

Female

**Date of Admission** 08-Jun-2022

**Date of Discharge**  
**MLC No**

**Address**

JAGITYAL,Karimnagar,Telangana

**Ward/Bed No** First  
Floor,  
CICU ,  
Bed  
no:CICU1  
1

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE AWMI

MODERATE LV DYSFUNCTION, EF-35%

R/F: HTN

CORONARY ANGIOGRAM DONE ON 11/06/2022 - CAD-DVD (LAD, RCA)

PTCA+DES TO LAD WITH 3.0 X 18 MM PRONOVA DONE ON 11/06/2022  
MEDICAL MANAGEMENT FOR RCA [CTO]

C/o chest pain a/w SOB since 3 days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 68years old female patient Mrs. J SUSHEELA came with c/o chest pain a/w SOB since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, MODERATE LV DYSFUNCTION, EF-35%, R/F: HTN, CORONARY ANGIOGRAM DONE ON 11/06/2022 – CAD-DVD (LAD, RCA), PTCA+DES TO LAD WITH 3.0 X 18 MM PRONOVA [LOT NO: CC200530018038, S/N :9990] DONE ON 11/06/2022. MEDICAL MANAGEMENT FOR RCA [CTO]. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPITAB 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. CILODOC 50MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 4) TAB. STORVAS 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. BETALOC 50MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 6) TAB. RAMISTAR 2.5 MG ONCE DAILY AT 8AM TO CONTINUE.
- 7) TAB. FRUSELAC ONCE DAILY AT 2PM TO CONTINUE.
- 8) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001231974

**Name**

Mr.  
GANGADHAR  
BUDDARAPU

**Patient Identifier**

ARHIP56104

**Age**

52Yr  
0Mth  
4Days

**Sex**

Male

**Date of Admission**

10-Jun-  
2022

**Date of Discharge**  
**MLC No**

**Address**

ANGADI  
BAZAR,JAGTIAL,Other,Telangana

**Ward/Bed No**

First  
Floor,  
CICU ,  
Bed  
no:CICU  
1

**Primary Consultant**

Dr. KRISHNA CHAITANYA M

CORONARY ARTERY DISEASE, AWSTEMI

MODERATE LV DYSFUNCTION, EF-35%

R/F: T2DM

S/P CORONARY ANGIOGRAM DONE ON 13/06/2022 - CAD-TVD

PLAN CABG.

C/o sudden onset chest pain followed by profuse sweating

No history of syncope, pedal oedema, breathing difficulty

At Admission

Afebrile

PR: 93/min

BP: 130/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-99%

A 52 years old male patient Mr. GANGADHAR BUDDARAPU had history of chest discomfort and profuse sweating was assessed at local hospital where he was managed as STEMI - Anterior wall and thrombolised with Tenecteplase 35 mg. He was referred to us for further management, on evaluation, he was asymptomatic, haemodynamically stable. ECG showed significant ST resolution. On Coronary Angiogram showed Triple Vessel Disease with a calcific thrombotic LAD, significant ( $> 70\%$ ) lesion in RCA and LCX. We advised myocardial viability testing (cardiac MRI, Trilium) for LAD territory. If LAD territory is viable, explained that CABG is the first option, in case LAD territory is non-viable, advised re-vascularization of RCA and LCX. Patient family wanted to taken him for Higher Centre for CABG. Hence being discharged for further management, he was asymptomatic at rest and haemodynamically stable at discharge.

#### DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPITAB 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. PAN 40 MG ONCE DAILY AT 7AM FOR 11 DAYS
5. TAB. MET-XL 50MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0001232104

**Name**

Mr. G  
LOKESH

**Patient Identifier**

ARHIP56173

**Age**

36Yr  
0Mth  
0Days

**Sex**

Male

**Date of  
Admission**

14-Jun-  
2022

**Date of Discharge  
MLC No**

**Address**

jagityal,Karimnagar,Telanga  
na

**Ward/  
Bed No**

First  
Floor,  
MICU,  
Bed  
no:MIC  
U 9

**Primary Consultant**

Dr. KRISHNA CHAITANYA M --  
CARDIOLOGY

MINOR CORONARY ARTERY DISEASE

CORONARY ANGIOGRAM (14/06/2022) -LAD SLOW FLOW

C/o palpitations, left sided chest pain a/w SOB since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 83/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 36 years old male patient LOKESH came with c/o palpitations, left sided chest pain a/w SOB since 1 day. All necessary investigations were done and diagnosed as MINOR CORONARY ARTERY DISEASE, LAD SLOW FLOW, CORONARY ANGIOGRAM (14/06/2022) -LAD slow flow, PLAN MEDICAL MANAGEMENT . Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN AV 75/10 MG ONCE DAILY AT 8PM TO CONTINUE.
2. TAB. NIKORAN 5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

REVIEW AFTER 3 MONTHS / SOS

ARH1.0001232117

**Name**

Mr.  
BHOOMAIA  
H G

**Patient Identifier**

ARHIP56171

**Age**

62Yr  
0Mth  
1Days

**Sex**

Male

**Date of Admission** 14-Jun-2022

**Date of Discharge**

**MLC No**

**Address**

THEEGALAGUTTAPALLI,Karimnagar,Telangan  
a

**Ward/Bed No**

First  
Floor,  
MICU,  
Bed  
no:MIC  
U 8

**Primary Consultant**

Dr. KRISHNA CHAITANYA

CORONARY ARTERY DISEASE, AWM I

FAIR LV FUNCTION

CORONARY ANGIOGRAM DONE ON 14/06/2022 -CAD-SVD (LAD)

PLAN : PTCA+DES TO LAD [EARLY]

C/o chest discomfort, generalized bodyache

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 87/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft



A 62 years old male patient <sup>BHOOMAI AH</sup> came with c/o chest discomfort, generalized bodyache. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWTMI, FAIR LV FUNCTION , CORONARY ANGIOGRAM (14/06/2022) -CAD-SVD (LAD), In view of critical mid LAD 99% stenosis, he was advised to early angioplasty. Risk of total occlusion followed by sudden cardiac arrest explained due to relative.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. MET-XL 50MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. FLAVEDON MR 35MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. NIKORAN 5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. NITROCONTIN 2.6 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
8. TAB. AMLODAC 5 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001232060

**Name**

Mrs. DUDAM  
SATHTHAVVA

**Patient Identifier**

ARHIP56152

**Age**

54Yr  
5Mth  
2Days

**Sex**

Female

**Date of Admission**

13-Jun-  
2022

**Date of Discharge**

**MLC No**

**Address**

3-6-135, SHANTHI  
NAGAR, Sircilla, Telangana

**Ward/Bed No**

First  
Floor,  
HDU,  
Bed  
no:HD  
U 2

**Primary Consultant**

Dr. KRISHNA CHAITANYA M

CORONARY ARTERY DISEASE

CORONARY ANGIOGRAM (14/06/2022) -LAD -ECTATIC CORONARIES -SLOW FLOW

C/o chest pain since 5 days associated with sweatings

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 73/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 94%

P/A: Soft

A 54 years old female patient Mrs. DUDAM SATHAVVA came with c/o chest pain since 5 days associated with sweatings. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, CORONARY ANGIOGRAM (14/06/2022) -LAD - ECTATIC CORONARIES -SLOW FLOW. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN AV 75/10 MG ONCE DAILY AT 8PM TO CONTINUE.
2. TAB. STAMLO 5 MG ONCE DAILY AT 8AM TO CONTINUE.
3. TAB. NIKORAN 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. FLAVEDON MR AV 75/10 MG ONCE DAILY AT 8PM TO CONTINUE.
5. TAB. NIKORAN 5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH TSH, FLP, FBS, CBC, RP2

ARH1.0001231972

		Mrs. MANCHIKATLA VIJAYA	
<b>Name</b>			
<b>Patient Identifier</b>	ARHIP56098	<b>Age</b>	54Yr 0Mth 5Days
<b>Sex</b>	Female	<b>Date of Admission</b>	10-Jun-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	gandhi road, jagityal,Karimnagar,Telangana	<b>Ward/ Bed No</b>	First Floor, CICU , Bed no:CICU 3
<b>Primary Consultant</b>	Dr. KRISHNA CHAITANYA M		

ACS -AWSTEMI  
SEVERE LV DYSFUNCTION  
PULMONARY OEDEMA  
MILD MR  
HF  
CARDIOGENIC SHOCK  
KILLIP CLASS -III  
NOW S/P PRIMARY PTCA TO LAD TOTAL OCCLUSION WITH A 2.75 X 32 MM METAFOR STENT  
GOOD RESULT  
UNCONTROLLED DIABETES

C/o chest pain sudden onset, followed by profuse sweating  
History of cough+

Known case of hypertension, diabetes mellitus on regular treatment

AT ADMISSION:

Afebrile

PR: 104/min

BP: 140/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 54 years old female patient Mrs. MANCHIKATLA VIJAYA came with c/o chest pain sudden onset, followed by profuse sweating, history of cough+. All necessary investigations

were done and diagnosed as ACS -AWSTEMI, SEVERE LV DYSFUNCTION, PULMONARY OEDEMA , MILD MR , HF , CARDIOGENIC SHOCK , KILLIP CLASS -III , NOW S/P PRIMARY PTCA TO LAD TOTAL OCCLUSION WITH A 2.75 X 32 MM METAFOR STENT , GOOD RESULT , UNCONTROLLED DIABETES. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPIDOGREL 70MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS
- 5) TAB. ALDACTONE 25 MG ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. RAMISTAR 2.5 MG ONCE DAILY AT 8AM TO CONTINUE.
- 7) TAB. IVABID 5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 8) TAB. LASIX 40MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 9) TAB. ZORYL M2 **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 10) TAB. CARVEDILOL 6.25MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

REVIEW AFTER 7 DAYS [22/06/2022] TO CARDIAC OPD WITH CBC, EFT/SE, ECG, FBS, FLP REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001226434

		<b>Name</b>	Mrs. AKKALA SATTAVVA	
<b>Patient Identifier</b>	ARHIP56162	<b>Age</b>	40Yr 5Mth 14Days	
<b>Sex</b>	Female	<b>Date of Admission</b>	13-Jun-2022	
<b>Date of Discharge</b>				
<b>MLC No</b>				
<b>Address</b>	LAXETTIPET,MANCHERIAL,Tandur,Telangana		<b>Ward/ Bed No</b>	First Floor, SICU, Bed no:SICU 6
<b>Primary Consultant</b>	DR. SRI KARAN UDDESH --INTERNAL			

## PARTIAL HANGING

Alleged history of hanging at 2.10 p.m. on 13/06/2022

Initially treated at outside hospital in unresponsive state along with seizures, came here for further management

Known case of psychiatric illness not on regular medication

### AT ADMISSION:

Patient was on mechanical ventilator

GCS-2T/15

PR: 80/min

BP: 130/70 mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 40 years old female patient Mrs. AKKALA SATTAVVA patient presented with the above-mentioned complaints, patient was brought in an intubated state MRI brain and MRI cervical spine was done which revealed no significant abnormality. On the second day of hospitalisation patient

was weaned off ventilation and Psychiatric consultation was taken. Patient condition improved. Patient is being discharged in hemodynamically stable condition.

DISCHARGE MEDICATION:

-----

1) TAB. SIZODON 1 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS

2) TAB. PACITANE 2 MG THRICE DAILY AT 8AM, 2PM AND 8PM FOR 7 DAYS

REVIEW AFTER 7 DAYS TO GENERAL MEDICINE OPD



ARH1.0001231889

<b>Name</b>	Mrs. SHOBA VELMALA		
<b>Patient Identifier</b>	ARHIP56076	<b>Age</b>	38Yr 0Mth 6Days
<b>Sex</b>	Female	<b>Date of Admission</b>	09-Jun-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	NIRAMAL,Karimnagar,Telangana	<b>Ward/ Bed No</b>	First Floor, CICU , Bed no:CICU 9
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY		

COMPLETE HEART BLOCK  
NORMAL LV SYSTOLIC FUNCTION, EF 56%  
TPI DONE ON 12/06/2022  
PPI DONE ON 12/06/2022 WITH MEDTRONIC [VVIR] DONE ON 12/06/2022

C/o chest pain radiating to back a/w SOB since 1 day

AT ADMISSION:

Afebrile

PR: 39/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 96%

P/A: Soft

A 38years old female patient Mrs. SHOBA VELMALA came with c/o chest pain radiating to back a/w SOB since 1 day. All necessary investigations were done and diagnosed as COMPLETE HEART BLOCK, NORMAL LV SYSTOLIC FUNCTION, EF 56%, TPI

DONE ON 12/06/2022, PPI DONE ON 12/06/2022 WITH MEDTRONIC [VVIR] DONE ON 12/06/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

-----

- 1) TAB. AUGMENTIN DUO 625MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS
- 2) TAB. BEPLEX FORTE ONCE DAILY AT 2PM FOR 10 DAYS
- 3) T-BACT OINTMENT FOR L/A
- 4) TAB. ULTRACET **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS
- 5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 7 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001231918

		<b>Name</b>	Mrs. SHANTHA ERLA	EDIT
<b>Patient Identifier</b>	ARHIP56085	<b>Age</b>	56Yr 0Mth 6Days	
<b>Sex</b>	Female	<b>Date of Admission</b>	09-Jun-2022	
<b>Date of Discharge</b>				
<b>MLC No</b>				
<b>Address</b>	KAGAZNAGAR,Tandur,Telangana	<b>Ward/ Bed No</b>	First Floor, CICU , Bed no:CICU 4	
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, ACUTE AWM I

MILD MR, SR

MILD LV DYSFUNCTION, EF-50%

R/F: ALCOHOLIC

CORONARY ANGIOGRAM DONE ON 16/10/2021 - CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.0 X 29 MM METAFOR DONE ON 16/10/2021

C/o SOB on exertion, chest pain since 5 days

AT ADMISSION:

Afebrile

PR: 79/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 52years old male patient Mr. GANDLA SHANKARAI AH came with c/o SOB on exertion, chest pain since 5 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWTMI, MILD MR, SR, MILD LV DYSFUNCTION, EF-50%, CORONARY ANGIOGRAM DONE ON 16/10/2021 - CAD-SVD (LAD), Type-III vessel, proximal LAD significant stenosis. PTCA+DES TO LAD WITH 3.0 X 29 MM METAFOR DONE ON 16/10/2021. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASUDOC 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. SARTEL 40 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. FRUSELAC ONCE DAILY AT 2PM TO CONTINUE.
- 6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER /  
EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW  
REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL  
CENTER AT- 0878-2200000.

ARH1.0001232075

		<b>Name</b>	Mrs. BAILU RAJAMMA	
<b>Patient Identifier</b>	ARHIP56146	<b>Age</b>	60Yr 0Mth 2Days	
<b>Sex</b>	Female	<b>Date of Admission</b>	13-Jun-2022	
<b>Date of Discharge</b>				
<b>MLC No</b>				
<b>Address</b>	8-129, UPPARAPALLI, ODELA, PEDDAPALLI, Karimnagar, Telangana		<b>Ward/ Bed No</b>	Ground Floor, Emergency Ward, Bed no: EME2
<b>Primary Consultant</b>	DR. SRI KARAN UDDESH --			

COMPLICATED UTI,  
RENAL CALCULI

C/o fever associated with pain abdomen, burning micturition  
Known case of type II diabetes mellitus, hypertension on regular medication

AT ADMISSION:

Afebrile

PR: 65/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 60 years old female patient Mrs. BAILU RAJAMMA came with above mentioned complaints. Patient diagnosed as COMPLICATED UTI, RENAL CALCULI. Patient was treated with antibiotics. Patient's condition improved since admission. CT-KUB done and Urologist consultation taken and advised surgery for left renal calculi. Now Patient attendants requested for discharge, hence patient is being discharged at request.

DISCHARGE MEDICATION:

-----

- 1) TAB. LEVOFLOX 500 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS
- 2) TAB. URIMAX 0.4 MG ONCE DAILY AT 2PM FOR 7 DAYS
- 3) SYP. POTKLAR 15 ML THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 1 DAY

REVIEW AFTER 7 DAYS TO GENERAL MEDICINE OPD



ARH1.0001232095

	Name	Mrs. KOMALA PANJALA		
Patient Identifier	ARHIP56161	Age	33Yr 0Mth 2Days	
Sex	Female	Date of Admission	13-Jun-2022	
Date of Discharge				
MLC No				
Address	CENTINARY COLONY,Karimnagar,Telangana	Ward/ Bed No	First Floor, HDU, Bed no:HD U 5	
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

ATYPICAL CHEST PAIN, SR  
NORMAL LV SYSTOLIC FUNCTION  
HYPOTHYROIDISM  
CORONARY ANGIOGRAM DONE ON 14/06/2022-NORMAL CORONARIES  
ADV: MEDICAL MANAGEMENT

C/o left sided chest pain radiating to left arm since 10 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 78/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 33 years old female patient Mrs. KOMALA PANJALA came with c/o left sided chest pain radiating to left arm since 10 days. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN, SR, NORMAL LV SYSTOLIC FUNCTION, HYPOTHYROIDISM, CORONARY ANGIOGRAM DONE ON 14/06/2022-NORMAL CORONARIES, ADV: MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. CLOPITAB 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. ATORVA 20MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. ULTRACET **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS.
4. TAB. THYRONORM 50 MCG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001231918

<b>Name</b>	Mrs. SHANTHA ERLA		
<b>Patient Identifier</b>	ARHIP56085	<b>Age</b>	56Yr 0Mth 6Days
<b>Sex</b>	Female	<b>Date of Admission</b>	09-Jun-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	KAGAZNAGAR,Tandur,Telangana	<b>Ward/ Bed No</b>	First Floor, CICU , Bed no:CICU 4
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, NON-ST ELEVATION MYOCARDIAL INFARCTION  
NORMAL LV SYSTOLIC FUNCTION, EF- 60%  
CORONARY ANGIOGRAM DONE ON 11/06/2022 - CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.0 X 23 MM PRONOVA DONE ON 11/06/2022  
R/F: HYPERTENSION

C/o SOB on exertion, chest pain, b/l pedal edema since 1 day

AT ADMISSION:

Afebrile

PR: 81/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 56years old female patient Mrs. SHANTHA ERLA came with c/o SOB on exertion, chest pain, b/l pedal edema since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NON-ST ELEVATION MYOCARDIAL INFARCTION, NORMAL LV SYSTOLIC FUNCTION, EF- 60%, CORONARY ANGIOGRAM DONE ON 11/06/2022 – CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.0 X 23 MM PRONOVA DONE ON 11/06/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASUDOC 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. TELZY-CT ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. METOLOR-XR 50 MG ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. GLYCOMET SR 500 MG ONCE DAILY AT 8AM TO CONTINUE.
- 7) TAB. SPOROLAC DS TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS

REVIEW AFTER 7 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.00010485  
29

**Name** Mr.  
CHEKKILA  
RAMULU

**Patient Identifier**

ARHIP56182

**Sex**

Male

**Date of Discharge**

**MLC No**

**Address**

2-1-109/2, SRI RAMNAGAR,  
JAGITIAL,,Karimnagar,Andhra Pradesh

**Primary Consultant**

Dr. KRISHNA CHAITANYA

**Age**

52Yr 7Mth  
18Days

**Date of Admission**

14-Jun-  
2022

**Ward/Bed No**

Ground  
Floor,  
Emergency Ward,  
Bed  
no:EME4

CORONARY ARTERY DISEASE  
S/P PTCA TO LAD  
FAIR LV FUNCTION  
NOW, CHEST PAIN FOR EVALUATION  
LAD STENT PATENT  
RCA PROXIMAL 40% STENOSIS  
MEDICAL MANAGEMENT

C/o Sudden onset of left sided chest pain associated with shortness of breath

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 85/min

BP: 90/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 52 years old male patient Mr. CHEKKILA RAMULU came with c/o Sudden onset of left sided chest pain associated with shortness of breath. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, S/P PTCA TO LAD, FAIR LV FUNCTION, NOW, CHEST PAIN FOR EVALUATION, LAD STENT PATENT, RCA PROXIMAL 40% STENOSIS, MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. ROSUVAS 20MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. MET-XL 25MG ONCE DAILY AT 8AM TO CONTINUE.
4. TAB. NIKORAN 5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

REVIEW AFTER 3 MONTHS TO CARDIAC OPD WITH APOLLO HEALTHY HEART PACKAGE

ARH1.0001132925		<b>Name</b>	Mr. PULLOORI SWAMI
<b>Patient Identifier</b>	ARHIP56096	<b>Age</b>	43Yr 0Mth 2Days
<b>Sex</b>	Male	<b>Date of Admission</b>	10-Jun-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	BRAHMANPALLY,Karimnagar,Telangana	<b>Ward/Bed No</b>	First Floor, HDU, Bed no:HD U 10
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE IWM

MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%

S/P PTCA STENT TO LAD (2017)

CORONARY ANGIOGRAM DONE ON 13/06/2022 - CAD-SVD (RCA)

PTCA+DES TO RCA WITH 3.5 X 37 MM METAFOR DONE ON 13/06/2022

C/o chest pain a/w mild sweating since 1 day

AT ADMISSION:

Afebrile

PR: 87/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft



A 43 years old male patient Mr. PULLOORI SWAMI came with c/o chest pain a/w mild sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%, S/P PTCA STENT TO LAD (2017), CORONARY ANGIOGRAM DONE ON 13/06/2022 - CAD-SVD (RCA), PTCA+DES TO RCA WITH 3.5 X 37 MM METAFOR [LOT NO: MH22, S/N :CM37MH22002] DONE ON 13/06/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 75 MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASUDOC 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001231920

<b>Name</b>	Mr. PARSHARAM KAVVAMPALLY		
<b>Patient Identifier</b>	ARHIP56084	<b>Age</b>	52Yr 0Mth 6Days
<b>Sex</b>	Male	<b>Date of Admission</b>	09-Jun-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	GANNERVARAM,Karimnagar,Telangana	<b>Ward/ Bed No</b>	First Floor, CICU , Bed no:CICU12
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, NSTEMI

MILD LV SYSTOLIC DYSFUNCTION, EF-50%

CORONARY ANGIOGRAM DONE ON 13/06/2022 - CAD-DVD (LAD, RCA)

PTCA+DES TO RCA & LAD (TWO STENTS ) LAD WITH 3.0 X 24 MM METAFOR, RCA WITH 3.0 X 44 MM METAFOR  
DONE ON 13/06/2022

C/o chest pain since 2 days a/w sweating, giddiness

AT ADMISSION:

Afebrile

PR: 78/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 19/min

SPO2: 99%

P/A: Soft

A 52 years old male patient Mr. PARSHARAM KAVVAMPALLY came with c/o chest pain since 2 days a/w sweating, giddiness. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, MILD LV SYSTOLIC DYSFUNCTION, EF-50%, CORONARY ANGIOGRAM DONE ON 13/06/2022 – CAD-DVD (LAD, RCA), PTCA+DES TO RCA & LAD (TWO STENTS ) LAD WITH 3.0 X 24 MM METAFOR, RCA WITH 3.0 X 44 MM METAFOR [LOT NO: MH42, S/N :CM24MH42083] [LOT NO: MG92, S/N :CM44MG92015] DONE ON 13/06/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. CILODOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 4) TAB. ATORVA 80MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001232008

		Mrs. LOKURTHI ANJALI	
<b>Patient Identifier</b>	ARHIP56126	<b>Age</b>	47Yr 5Mth 4Days
<b>Sex</b>	Female	<b>Date of Admission</b>	11-Jun-2022
<b>Date of Discharge MLC No</b>			
<b>Address</b>	2-28/1, KORUTLAPETA,RAJANNA,Sircilla,Telangan a	<b>Ward/ Bed No</b>	First Floor, HDU, Bed no:HD U 7
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY		

ATYPICAL CHEST PAIN WITH ECG CHANGES, SR

NORMAL LV SYSTOLIC FUNCTION [EF-60%]

R/F: HTN

CORONARY ANGIOGRAM (14/06/2022) -NORMAL CORONARIES

ADV: MEDICAL MANAGEMENT

C/o chest pain on and off, SOB on exertion since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 90/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft

A 47 years old female patient Mrs. LOKURTHI ANJALI came with c/o chest pain on and off, SOB on exertion since 1 day. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN WITH ECG CHANGES, SR, NORMAL LV SYSTOLIC FUNCTION [EF-60%], R/F: HTN, CORONARY ANGIOGRAM (14/06/2022) -NORMAL CORONARIES, ADV: MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. TONACT 20MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. PROLOMET-R 25/2.5 ONCE DAILY AT 8AM TO CONTINUE.
4. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 11 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001232062

**Name**

Mrs. B  
VENKATA  
NARSAMMA

**Patient Identifier**

ARHIP56145

**Age** 57Yr 5Mth  
14Days

**Sex**

Female

**Date of Admission** 13-Jun-2022

**Date of Discharge**  
**MLC No**

**Address**

RAMADUGU,,Karimnagar,Telangana

**Ward/Bed No** Ground Floor,  
Emergency Ward,  
Bed no:EME5

**Primary Consultant**

DR. SRI KARAN UDDESH

COMPLICATED UTI,  
RENAL CALCULI

C/o fever associated with pain abdomen, burning micturition since 3-4 days

Known case of hypertension on regular medication

AT ADMISSION:

Afebrile

PR: 88/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98% on room air

P/A: Soft

A 57 years old female patient Mrs. B VENKATA NARSAMMA came with above mentioned complaints. Patient diagnosed as COMPLICATED UTI, RENAL CALCULI. Patient was treated with antibiotics. Patient's condition improved since admission. CT-KUB done and Urologist consultation taken and advised surgery Right DJ stent, for right PUJ calculus. Now Patient attendants requested for discharge, hence patient is being discharged at request.



DISCHARGE MEDICATION:

-----

- 1) TAB. LEVOFLOX 500 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS
- 2) TAB. URIMAX 0.4 MG ONCE DAILY AT 2PM FOR 7 DAYS
- 3) SYP. POTKLAR 15 ML THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 1 DAY

REVIEW AFTER 7 DAYS TO GENERAL MEDICINE OPD

ARH1.0001231981

<b>Name</b>	Mr. RAJAIAH S		
<b>Patient Identifier</b>	ARHIP56115	<b>Age</b>	69Yr 0Mth 6Days
<b>Sex</b>	Male	<b>Date of Admission</b>	10-Jun-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	BHAGATH NAGAR,Karimnagar,Telangana	<b>Ward/ Bed No</b>	First Floor, RECOVERY ROOM, Bed no:RR 8
<b>Primary Consultant</b>	Dr. KRISHNA CHAITANYA M --		

CORONARY ARTERY DISEASE, IWSTEMI [THROMBOLISED BY TENECTEPLASE (OUTSIDE)]

FAIR LV FUNCTION, LVEF-50%

S/P PTCA TO RCA (2 STENTS) WITH METAFOR [2.75 X 40 mm], METAFOR [2.5 X 16 mm] done on 13.06.2022

NO HF

FC I AT REST

LMCA+LAD MILD DISEASE FOR MEDICAL MANAGEMENT NOW

C/o Retrosternal chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 65/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 69 years old male patient RAJAIAH came with history of chest pain was diagnosed as I/STEMI and thrombolised with TENECTEPLASE at a local hospital and referred to us for further management. On evaluation patient was taken up for CAG which showed two RCA lesions. RCA was revascularized with 2 stents. He also has mild LMCA and ostio-proximal LAD disease which were planned for medical management with high intensity statin therapy. He improved symptomatically and became better. He was haemodynamically stable and hence, being discharged with the following advice.

#### DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 80MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. NIKORAN 5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. FLAVEDAN MR 35MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. MET-XL 25 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW ON 22/06/22 TO CARDIAC OPD WITH CBC, RP-2 REPORTS

ARH1.0001162967

		<b>Name</b>	Mr. LACHI REDDY GAGIREDDY	
<b>Patient Identifier</b>	ARHIP56155	<b>Age</b>	58Yr 9Mth 1Days	
<b>Sex</b>	Male	<b>Date of Admission</b>	13-Jun-2022	
<b>Date of Discharge</b>				
<b>MLC No</b>				
<b>Address</b>	kachapur,peddapalli,Karimnagar,Telangan		<b>Ward/Bed No</b>	First Floor, HDU, Bed no:HD U 3
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, ACUTE AWM I

MILD LV DYSFUNCTION, EF-45%

S/P CORONARY ANGIOGRAM DONE ON 13/04/2022 - CAD-TVD (LAD, LCX, RCA)

CABG WITH GRAFT TO LAD, RAMUS, RCA

R/F: HTN

C/o Retrosternal chest pain since 1 day

At Admission

Afebrile

PR: 78/min

BP: 120/80 mmHg

RR-18/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-96%

A 58 years old male patient Mr. LACHI REDDY GAGIREDDY came with c/o retrosternal chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWTMI, MILD LV DYSFUNCTION, EF-45%, S/P CORONARY ANGIOGRAM DONE ON 13/04/2022 - CAD-TVD (LAD, LCX, RCA), Patient is planned for CABG WITH GRAFT TO LAD, RAMUS, RCA. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ROZAVEL 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.
5. SYP. POTKLOR 15 ML THRICE DAILY AT 8AM, 2PM, 8PM

REVIEW AFTER 11 DAYS IN CARDIAC OPD

ARH1.0001232043

**Name**

Mrs.  
PREAMALATHA  
G

**Patient Identifier**

ARHIP56141

**Age**

69Yr  
0Mth  
3Days

**Sex**

Female

**Date of Admission**

13-Jun-  
2022

**Date of Discharge**  
**MLC No**

**Address**

11-2-303 INDIRA  
NAGAR,Karimnagar,Telanga  
na

**Ward/Bed  
No**

First  
Floor,  
CICU ,  
Bed  
no:CICU  
2

**Primary Consultant**

Dr. Vidya Sagar A--  
CARDIOLOGY

CORONARY ARTERY DISEASE , ACUTE LVF

SEVERE LV DYSFUNCTION, EF-30%

S/P CORONARY ANGIOGRAM DONE ON 15/06/2022 - CAD-TVD

ADV: CABG.

R/F HTN,

C/o chest pain a/w SOB, mild sweating since 1 day

At Admission

Afebrile

PR: 86/min

BP: 140/90 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-99%

A 69 years old female patient Mrs. PREAMALATHA G came with c/o chest pain a/w SOB, mild sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , ACUTE LVF, SEVERE LV DYSFUNCTION, EF-30% , S/P CORONARY ANGIOGRAM DONE ON 15/06/2022 - CAD-TVD, ADV: CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPIDOGREL 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. CARDIVAS 3.125 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. RAMISTAR 2.5 MG ONCE DAILY AT 8PM TO CONTINUE.
6. TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.
7. CAP. ANGISPAN TR 2.5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
8. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 10 DAYS IN CARDIAC OPD

ARH1.0001232096

**Name**

Mr. G  
CHANDRAIA  
H

**Patient Identifier**

ARHIP56164

**Age**

62Yr 0Mth  
3Days

**Sex**

Male

**Date of  
Admission**

13-Jun-  
2022

**Date of Discharge  
MLC No**

**Address**

POLAMPALLI THIMMAPUR  
KARIMNAGAR, Karimnagar, Telang  
ana

**Ward/Bed  
No**

First Floor,  
RECOVERY  
ROOM, Bed  
no:RR 3

**Primary Consultant**

DR. SUBRAT KUMAR SOREN --  
NEUROSURGERY

**RTA POLYTRAUMA  
SEVERE TRAUMATIC BRAIN INJURY  
MULTIPLE HAEMORRHAGIC CONTUSIONS BILATERAL BASIFRONTAL,  
BASITEMPORAL  
BILATERAL THIN ACUTE SDH  
FRACTURE GREATER WING OF SPHENOID, TEMPORAL BONE, MASTOID RIGHT SIDE  
DIFFUSE CEREBRAL EDEMA  
BRUST LEFT TEMPORAL LOBE WITH MASS EFFECT  
SAH  
COMMINUTED FRACTURE HUMERUS LEFT  
FRACTURE LEFT 4TH METATARSAL LEFT  
FRACTURE LATERAL MALLEOLUS LEFT  
SURGERY: LEFT SIDE FTP DECOMPRESSIVE CRANIECTOMY DONE ON 14/06/2022**

Alleged history of RTA 2 wheeler Vs Tractor at 5 p.m. on 13/60/2022 followed by sustained polytrauma injury

History of LOC, Vomitings, ENT bleeding present

PHYSICAL EXAMINATION:

ON ADMISSION

-----

Patient is unconscious

PR-96/min



BP-120/80mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

P/A-Soft

SPO2-99% with O2 support

GCS E1, V1, M3

A 62 yrs old male patient <sup>Mr. CHANDRAIAH</sup> came with alleged history of RTA 2 wheeler Vs Tractor at 5 p.m. on 13/60/2022 followed by sustained polytrauma injury , history of LOC, Vomittings, ENT bleeding present. Patient was intubated in view of threatened airway and aspirations. All necessary investigations done and diagnosed as RTA POLYTRAUMA, SEVERE TRAUMATIC BRAIN INJURY, MULTIPLE HAEMORRHAGIC CONTUSIONS BILATERAL BASIFRONTAL, BASITEMPORAL, BILATERAL THIN ACUTE SDH, FRACTURE GREATER WING OF SPHENOID, TEMPORAL BONE, MASTOID RIGHT SIDE ,DIFFUSE CEREBRAL EDEMA, BRUST LEFT TEMPORAL LOBE WITH MASS EFFECT, SAH, COMMINUTED FRACTURE HUMERUS LEFT, FRACTURE LEFT 4TH METATARSAL LEFT , FRACTURE LATERAL MALLEOLUS LEFT . SURGERY: LEFT SIDE FTP DECOMPRESSIVE CRANIECTOMY DONE ON 14/06/2022. Post operative period was uneventful. Orthopaedic consultation taken and advice followed. Patient condition and need for further hospitalization explained to patient attendants but they want to discharge against medical advice, so patient is being discharged under DAMA.

ARH1.000116729  
0

**Name**

Mr. ALETI  
LINGAIAH

**Patient  
Identifier**

ARHIP56119

**Age**

59Yr  
6Mth  
24Days

**Sex**

Male

**Date of  
Admission**

10-Jun-  
2022

**Date of  
Discharge  
MLC No**

**Address**

PALTHEM,PEDDAPALLI,Karimnagar,Telang  
ana

**Ward/  
Bed No**

First  
Floor,  
CICU ,  
Bed  
no:CICU  
3

**Primary  
Consultant**

Dr. KRISHNA CHAITANYA M --CARDIOLOGY

CORONARY ARTERY DISEASE, OLD AWMI  
S/P PTCA TO LAD [2018]

NOW ACS NSTEMI,

S/P PTCA TO RCA (2 STENTS) WITH 3V ASTRA [3.0 X 36 mm], 3 V ASTRA [3.0 X 12  
mm] done on 14.06.2022

GOOD RESULT

C/o chest pain, SOB on exertion since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 56/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

Mr. ALETI LINGAIAH, 59 years old gentleman is a known case of CAD, S/P PTCA to LAD in 2018, now presented with chest pain, on evaluation diagnosed as ACS-NSTEMI. CAG done showed RCA 80% stenosis, RCA was revascularised with 2 stents. Good result. He is symptomatically better and haemodynamically stable, hence being discharged with following advice.

#### DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.
5. TAB. NIKORAN 5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. FLAVEDAN MR 35MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. MET-XL 12.5 MG ONCE DAILY AT 8AM TO CONTINUE.
8. TAB. RAMISTAR 1.25 MG ONCE DAILY AT 8AM TO CONTINUE.
9. TAB. FRUSELAC ½ TAB ONCE DAILY AT 8AM TO CONTINUE.

REVIEW ON 22/06/22 TO CARDIAC OPD WITH CBC, RP-2 REPORTS

ARH1.0001231990

Name

Mrs. K  
BHAGYA  
LAXMI

**Patient Identifier** ARHIP56122

**Age** 75Yr  
0Mth  
6Days

**Sex** Female

**Date of Admission** 11-Jun-2022

**Date of Discharge** 12-Jun-2022  
**MLC No**

**Address** h no-7-4-  
18,vijayapuri,jagityal,Karimnagar,Telanganangana

**Ward/Bed No** First Floor,  
HDU,  
Bed no:HD  
U 10

**Primary Consultant** Dr. Vidya Sagar A--CARDIOLOGY

**Consultants**

**Surgeons** Dr. Vidya Sagar A--CARDIOLOGY

**Anesthesiologists**

Diagnosis

Diagnosis

Disease	Disease Type
ACUTE GASTROENTERITIS;EVALUATION FOR ECG CHANGES (LBBB+VPL)PARADOXICAL SEPTAL MOTION;MILD AR/PAH SR,MODARATE LV SYSTOLIC DYSFUNCTION(EF-35%) CAG DONE ON(11/06/2022)-CAD MILD DISEASE. ADV-MEDICAL MANAGEMENT.	

ACUTE GASTROENTERITIS;EVALUATION FOR ECG CHANGES (LBBB+VPL)PARADOXICAL SEPTAL MOTION;MILD AR/PAH SR,MODARATE LV SYSTOLIC DYSFUNCTION(EF-35%)  
CAG DONE ON(11/06/2022)-CAD MILD DISEASE.  
ADV-MEDICAL MANAGEMENT.

C/o Sudden onset of vomitings 10 episodes and loose motions 10-12 episodes since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 109/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 75 years old female patient BHAGYA LAXMI came with c/o Sudden onset of vomitings 10 episodes and loose motions 10-12 episodes since 1 day. All necessary investigations were done and diagnosed as ACUTE GASTROENTERITIS; EVALUATION FOR ECG CHANGES (LBBB+VPL) PARADOXICAL SEPTAL MOTION; MILD AR/PAH SR, MODERATE LV SYSTOLIC DYSFUNCTION (EF-35%), CAG DONE ON (11/06/2022) - CAD MILD DISEASE, ADV-MEDICAL MANAGEMENT. Patient was treated with antiplatelets, anticoagulation, antacids and other supportive measures. Patient is being discharged in hemodynamically stable condition with required medication and advise.

#### DISCHARGE MEDICATION:

-----

1. TAB. CONCOR 5 MG ONCE DAILY AT 8AM TO CONTINUE.
2. TAB. ECOSPRIN-AV 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. PANTOCID 40 MG ONCE DAILY AT 7AM BBF FOR 11 DAYS
4. TAB. REDOTIL ONCE DAILY AT 8AM SOS
5. TAB. THYRONORM 12.5 MCG ONCE DAILY AT 8AM TO CONTINUE.
6. CAP. SPOROLAC DS **TWICE IN A DAY AT 8 AM 8 PM**
7. ORS SACHETS SOS

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001232035

**Name**

Mr. T  
RAJENDER  
SINGH

**Patient  
Identifier**

ARHIP56137

**Age**

42Yr  
0Mth  
5Days

**Sex**

Male

**Date of  
Admission**

12-  
Jun-  
2022

**Date of  
Discharge**

12-Jun-2022

**MLC No**

**Address**

Husnabad,Karimnagar,Telangana

**Ward/Bed No**

First  
Floor,  
Day  
Care,  
Bed  
no:D  
C 2

**Primary  
Consultant**

Dr. Vidya Sagar A--  
CARDIOLOGY

**Consultants**

**Surgeons**

Dr. Vidya Sagar A--  
CARDIOLOGY

**Anesthesiologists**

Diagnosis

**Diagnosis**

Disease

Disease  
Type

ATYPICAL CHEST PAIN,SINUS RHYTHM,  
SR,NORMAL LV FUNCTION,  
CAG DONE ON (12/06/2022),  
NORMAL CORONARIES,  
PLAN; MEDICAL MANAGEMENT.  
R/F;HYPERTENSION.

C/o Sudden onset of chest pain,  
H/o mild sweating and mild SOB

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 64/min

BP: 140/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 42 years old male patient Mr. T RAJENDER SINGH came with c/o Sudden onset of chest pain, h/o mild sweating and mild SOB. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN, SINUS RHYTHM, SR, NORMAL LV FUNCTION, CAG DONE ON (12/06/2022), NORMAL CORONARIES, PLAN; MEDICAL MANAGEMENT. Patient was treated with antiplatelets, anticoagulation, antacids and other supportive measures. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. TONACT 40 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. PANTOCID 40 MG ONCE DAILY AT 7AM BBF FOR 11 DAYS
4. TAB. ULTRACET **TWICE IN A DAY AT 8 AM 8 PM** FOR 7DAYS
5. SYP. GASTRACID 2tsp **TWICE IN A DAY AT 8 AM 8 PM**

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001232084

**Name**

Mr. NALLAPU  
MAHENDAR

**Patient  
Identifier**

ARHIP56151

**Age**

27Yr  
0Mth  
4Days

**Sex**

Male

**Date of  
Admission**

13-Jun-  
2022

**Expired Date** 17-Jun-2022

**MLC No**

**Address**

H NO-3-  
28,SOMANAPALLI,Karimnagar,Telang  
ana

**Ward/Bed No**

First  
Floor,  
MICU,  
Bed  
no:MIC  
U 2

**Primary  
Consultant**

Dr. RAMCHANDER TORREM(MD  
(General Medicine),DM  
Nephrology(NIMS),Consultant  
Nephrologist)--NEPHROLOGY

**Consultants**

**Surgeons**

**Anesthesiologi  
sts**

Diagnosi  
S

**Diagnosis**

Disease	Disease Type
PARAQUAT POISONING	

Alleged history of consumption of paraquat poisoning around 125 ml at 1 p.m. on 13/06/2022

C/o throat pain , Shortness of breath

AT ADMISSION:

Patient c/c  
PR: 130/min

BP: 90/60 mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft



A 27 years old male patient Mr. NALLAPU MAHENDAR presented with alleged history of consumption of paraquat poisoning around 125 ml at 1 p.m. on 13/06/2022, c/o throat pain , Shortness of breath. All necessary investigations were done and diagnosed as PARAQUAT POISONING. 2 sessions Hemoperfusion done, 1 Unit FFP transfusion given in view of blood vomitings, On 17/06/2022 at 03.00 AM patient had sudden cardiac arrest. CPR was initiated as per ACLS protocols, inspite of best effort return of spontaneous circulation could not be obtained, hence patient was declared as dead at 03.37 AM on 17/06/2022.

#### CAUSE OF DEATH

-----

SUDDEN CARDIOPULMONARY ARREST SECONDARY TO PARAQUAT POISONING

56078

ARH1.0001231925

**Name** Mr. RAJENDER  
KATUKURI

**Patient Identifier** ARHIP56078

**Age** 51Yr 0Mth  
0Days

**Sex** Male

**Date of Admission** 09-Jun-2022

**Expired Date** 09-Jun-2022  
**MLC No**

**Address** KOTHAPALLY,Karimnagar,Telangana

**Ward/Bed No** Ground Floor,  
Emergency Ward,  
Bed no:EME 8

**Primary Consultant** Dr. Vidya Sagar A--CARDIOLOGY

**Consultants**

**Surgeons** Dr. Vidya Sagar A--CARDIOLOGY

**Anesthesiologists**

Diagnosis

**Diagnosis**

Disease	Disease Type
CORONARY ARTERY DISEASE ACUTE ANTERIOR WALL MYOCARDIAL INFARCTION.NO TLT,SEVERE LV SYSTOLIC DYSFUNCTION .EF:30%	

C/o chest pain since 3 days

AT ADMISSION:

PR: 72/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 51 years old male patient RAJENDER KATUKURI came with c/o chest pain since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE ACUTE ANTERIOR WALL MYOCARDIAL INFARCTION.NO TLT,SEVERE LV SYSTOLIC DYSFUNCTION .EF:30%. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and inotropic support

was given. CPR started immediately, continued for 45 minutes, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 02.00 PM on 09/06/2022.

## CAUSE OF DEATH

-----  
CORONARY ARTERY DISEASE ACUTE ANTERIOR WALL MYOCARDIAL INFARCTION.NO TLT,SEVERE LV SYSTOLIC DYSFUNCTION .EF:30%

ARH1.0001232022

**Name** Mrs. KONDLEPU  
LAXMI

**Patient Identifier** ARHIP56130

**Age** 61Yr  
5Mth  
2Days

**Sex** Female

**Date of Admission** 11-Jun-2022

**Expired Date** 13-Jun-2022  
**MLC No**

**Address** 1-4-135/5, ARAVINDU  
NAGAR,JAGTIAL,Karimnagar,Telanga  
na

**Ward/Bed No** First  
Floor,  
CICU ,  
Bed  
no:CICU1  
3

**Primary Consultant** Dr. Vidya Sagar A--CARDIOLOGY

**Consultants**

**Surgeons**

**Anesthesiologists**

Diagnosis

### Diagnosis

Disease	Disease Type
CORONARY ARTERY DISEASE ACUTE INFERIOR WALL MYOCARDIAL INFARCTION. MODERATE LV DYSFUNCTION EF 35%.	

C/o giddiness, profuse sweating with chest pain since 1 day

AT ADMISSION:

PR: 87/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2  
RR: 20/min  
SPO2: 98%  
P/A: Soft

A 61 years old female patient Mrs. KONDLEPU LAXMI came with c/o giddiness, profuse sweating with chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE ACUTE INFERIOR WALL MYOCARDIAL INFARCTION. MODERATE LV DYSFUNCTION EF 35%. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and inotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLS guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 06.40 PM on 13/06/2022.

## CAUSE OF DEATH

-----  
CARDIORESPIRATORY ARREST DUE TO CORONARY ARTERY DISEASE ACUTE ANTERIOR WALL MYOCARDIAL INFARCTION.NO TLT,SEVERE LV SYSTOLIC DYSFUNCTION .EF:30%

ARH1.000123198  
7

**Name** Mrs. PRAMILA  
**e** SUDDALA

**Patient Identifier** ARHIP56118

**Age** 53Yr  
0Mth  
5Days

**Sex** Female

**Date of Admission** 10-Jun-2022

**Expired Date** 15-Jun-2022

**MLC No**

**Address** H.NO:1-  
114,APPANNAPET,PEDDAPALLY,Other,Telangana

**Ward/Bed No** First  
Floor,  
CICU ,  
Bed  
no:CICU1

**Primary Consultant**

Dr. KRISHNA CHAITANYA M --CARDIOLOGY

**Consultants****Surgeons****Anesthesiologists**
☐ Diagnoses
**Diagnosis**[Add Diagnosis](#)

Disease	Disease Type
CAD IPWSTEMI,AKI.	

C/o chest pain since 1 day

**AT ADMISSION:**

PR: 82/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 53 years old female patient Mrs. PRAMILA SUDDALA came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CAD IPWSTEMI,AKI. Poor prognosis explained to the patient attendants, suddenly patient unconscious. INJ. Atropine and INJ. ADRENALINE given, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and ionotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 05.00 AM on 15/06/2022.

## CAUSE OF DEATH

-----  
CARDIOPULMONARY ARREST DUE TO CAD IPWSTEMI,AKI.

ARH1.0001232100

**Name**

Mr. GOPAL A

**Patient Identifier**

ARHIP56166

**Sex**

Male

**Expired Date**

17-Jun-2022

**MLC No**

**Address**

KMR,Karimnagar,Telangana

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

**Surgeons**

Dr. Vidya Sagar A--CARDIOLOGY

**Age**

56Yr 0Mth  
3Days

**Date of Admission**

14-Jun-2022

**Ward/Bed No**

First Floor,  
CICU ,  
Bed no:CICU13

**Consultants**

**Anesthesiologists**

Diagnosis

**Diagnosis**

Disease	Disease Type
CAD ACUTE AWTMI.	

C/o chest pain a/w SOB, vomitings since 1 day

AT ADMISSION:

PR: 86/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 56 years old male patient Mr. GOPAL A came with c/o chest pain a/w SOB, vomitings since 1 day. All necessary investigations were done and diagnosed as CAD ACUTE AWTMI. Poor prognosis explained to the patient attendants, suddenly patient unresponsive. INJ. Atropine and INJ.

ADRENALINE given, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and ionotropic support was given. CPR started immediately, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 03.31 AM on 17/06/2022.

## CAUSE OF DEATH

-----  
CARDIOPULMONARY ARREST DUE TO CAD ACUTE AWM

APJ1.0014502200		<b>Name</b>	Mr. Sreedhar Chittyala
<b>Patient Identifier</b>	ARHIP56138	<b>Age</b>	53Yr 7Mth 23Days
<b>Sex</b>	Male	<b>Date of Admission</b>	12-Jun-2022
<b>Date of Discharge</b>	12-Jun-2022		
<b>MLC No</b>			
<b>Address</b>	Hyderabad,Telangana	<b>Ward/Bed No</b>	First Floor, Day Care, Bed no:DC 1
<b>Primary Consultant</b>	Dr. KRISHNA CHAITANYA M -- CARDIOLOGY	<b>Consultants</b>	
<b>Surgeons</b>	Dr. KRISHNA CHAITANYA M -- CARDIOLOGY	<b>Anesthesiologists</b>	

☐ **Diagnosis**

**Diagnosis**

<b>Disease</b>	<b>Disease Type</b>
----------------	---------------------

CAD-CHEST PAIN  
NORMAL LV SYSTOLIC FUNCTION EF-60%  
CAG DONE ON (12/06/2022),  
CAG-LAD AND RCA ECTATIC CONONARIES WITH SLOW FLOW,  
PLAN;MEDICAL MANAGEMENT

C/o chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 53 years old male patient MR. SREEDHAR CHITTYALA came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CAD-CHEST PAIN, NORMAL LV SYSTOLIC FUNCTION EF-60%, CAG DONE ON (12/06/2022), CAG-LAD AND RCA ECTATIC CONONARIES WITH SLOW FLOW, PLAN;MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN AV 75/10 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. NIKORAN 5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS



REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.00011567 60	<u>ARHIP560</u> <u>40</u>	Mrs. KAMALA RANI SARDAR   Female   64Yr 0Mth 5Days	<b>MICU</b> <b>7</b>	07-Jun- 2022	Dr Chandra Shekar Sathineni
---------------------	------------------------------	---	-------------------------	-----------------	--------------------------------

## ACUTE EXACERBATION OF BRONCHIAL ASTHMA RENAL INSUFFICIENCY

C/o shortness of breath grade 2 to 3 since 3 days associated with bilateral pedal oedema  
Known case of bronchial asthma

AT ADMISSION:

Afebrile

PR: 115/min

BP: 100/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 60% on room air

P/A: Soft

A 64 years old female patient Mrs. KAMALA RANI SARDAR came with c/o shortness of breath grade 2 to 3 since 3 days associated with bilateral pedal oedema. Known case of bronchial asthma. All necessary investigations were done and diagnosed as ACUTE EXACERBATION OF BRONCHIAL ASTHMA, RENAL INSUFFICIENCY.

Patient was on NIV support in view of respiratory acidosis. Managed conservatively. Pulmonologist & Nephrologist consultations taken and advise followed . Patient attendants requested for discharge, hence patient is being discharge at request.

DISCHARGE MEDICATION:

- 1) TAB. FPM-ACT 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 2) TAB. LINOZEM 600 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 3) TAB. RAZO-D ONCE DAILY AT 7AM (BBF) FOR 5 DAYS.
- 4) TAB. RENOSAVE ONCE DAILY AT 2PM FOR 10 DAYS
- 5) TAB. PULMOCLEAR TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 6) NEBULIZATION WITH DUOLIN, BUDECORT
- 7) TAB. BILAHENZ-M ONCE DAILY AT 8PM FOR 10 DAYS
- 8) TAB. PREDMET 8 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS, THEN  
TAB. PREDMET 8 MG ONCE DAILY AT 2PM FOR 5 DAYS AND STOP
- 9) TAB. PIDOTIMMUNE 800 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

REVIEW AFTER 5 DAYS IN GENERAL MEDICINE OPD

ARH1.0001232101

**Name**

Mrs. RAJAMMA  
BONGANI

**Patient  
Identifier**

ARHIP56170

**Age**

63Yr  
0Mth  
4Days

**Sex**

Female

**Date of  
Admission**

14-Jun-  
2022

**Date of  
Discharge  
MLC No**

**Address**

1-85/1  
ENDAPALLY, Karimnagar, Telangana

**Ward/  
Bed No**

First  
Floor,  
MICU,  
Bed  
no: MIC  
U 3

**Primary  
Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, AWM I

RIGHT MONO HEMIPARESIS WITH APHASIA

C/o chest pain a/w SOB since 3-4 days

K/c/o T2DM, HTN

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 85/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 63 years old female patient Mrs. RAJAMMA BONGANI came with c/o chest pain a/w SOB since 3-4 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWTMI, RIGHT MONO HEMIPARESIS WITH APHASIA. Managed conservatively. Neurophysician consultation taken and advice followed. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

- 
1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
  2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
  3. TAB. TONACT 40MG ONCE DAILY AT 2PM TO CONTINUE.
  4. TAB. CONCOR COR 1.25 MG ONCE DAILY AT 8AM TO CONTINUE.
  5. TAB: FRUSELAC ONCE DAILY AT 8AM TO CONTINUE.
  6. INJ HUMAN INSULATARD S/C 12 Units AT 8AM AND 8PM CONTINUE
  7. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0001232134

**Name**

Mrs. N  
PUSHPALATHA

**Patient Identifier**

ARHIP56175

**Age**

65Yr  
0Mth  
1Days

**Sex**

Female

**Date of  
Admission**

14-Jun-  
2022

**Expired Date**

15-Jun-2022

**MLC No**

**Address**

KARIMNAGAR, Karimnagar, Telangana

**Ward/Bed No** First

Floor,  
MICU,  
Bed  
no:MIC  
U 12

**Primary Consultant**

Dr. RAMCHANDER TORREM(MD  
(General Medicine),DM  
Nephrology(NIMS),Consultant  
Nephrologist)--NEPHROLOGY

**Consultants**

**Surgeons**

**Anesthesiologists**

Diagnosis  
S

**Diagnosis**

Disease	Disease Type
.	

SEPTIC SHOCK WITH MULTIPLE ORGAN DYSFUNCTION SYNDROME

Fever with shortness of breath and generalised weakness since 2 days

Known case of hypertension, diabetes mellitus

AT ADMISSION:

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 65 years old female patient PUSHPALATHA came with c/o fever with shortness of breath and generalised weakness since 2 days. All necessary investigations were done and diagnosed as SEPTIC SHOCK WITH MULTIPLE ORGAN DYSFUNCTION SYNDROME. Poor prognosis explained to the patient attendants, suddenly patient unconscious. INJ. Atropine and INJ. ADRENALINE given, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and ionotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 12.39 PM on 15/06/2022.

### CAUSE OF DEATH

-----

CARDIOPULMONARY ARREST DUE TO SEPTIC SHOCK WITH MULTIPLE ORGAN DYSFUNCTION SYNDROME

56048  
Sunitha

ACUTE EXACERBATION OF BRONCHIAL ASTHMA  
ACUTE HEPATITIS  
HYPOKALAEMIA  
IRON DEFICIENCY ANAEMIA  
PROBABLE STRESS CARDIOMYOPATHY

C/o progressive dyspnoea, body ache since 7 days

Known case of bronchial asthma

AT ADMISSION:

Patient was intubated

PR: 112/min

BP: 120/70mmHg

RS: Bilateral extensive wheeze present

A 39 years old female patient SUNITHA presented with the above-mentioned complaints patient was diagnosed to have acute exacerbation of bronchial asthma. In view of severe type II respiratory failure patient was intubated. The patient was started on broad spectrum antibiotics along with METHYLPREDNISOLONE 60 mg IV 1-0-1. After 2 days of hospitalisation patient was extubated as the respiratory parameters improved. 24 hours post extubation patient develop severe type II respiratory failure again and was drowsy hence patient was re-intubated. 48 hours after re intubation patient was extubated. Patient was continued on NIV support throughout the hospital stay for the next 4 days of hospitalisation. 2D echo was done for the patient which showed severe LV dysfunction, Cardiologist consultation was taken and was advised similar medication suspecting stress cardiomyopathy. Blood culture and urine culture was sterile. Daily monitoring of electrolytes and creatinine was done. As patient had low haemoglobin 1 packed red cells blood transfusion was done. ANA profile for the patient was negative. Patient had thrombocytopenia which has now resolved. Patient had disseminated intravascular coagulation which is now resolved. Initially patient had acute hepatitis which has now resolved. Now the patient is haemodynamically stable and is maintaining saturation on room air and is hence being discharged with home BI-PAP at night and the following medications.



DISCHARGE MEDICATION:

- 1) TAB. GEROZ- LP ONCE DAILY AT 2PM FOR 10 DAYS
- 2) NEBULIZATION WITH DUOLIN EVERY 6<sup>th</sup> hrly FOR 10 DAYS
- 3) TAB. PAN 40 MG ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.
- 4) TAB. MONTEK-LC ONCE DAILY AT 8PM FOR 10 DAYS
- 5) SYP. ASCORYL-D 10 ml THRICE DAILY AT 8AM 2PM 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS IN GENERAL MEDICINE OPD WITH CBP, RP-II REPORTS

56214 hameed

CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SR

MILD LV DYSFUNCTION [EF-45%]

R/F : ALCOHOLIC

CORONARY ANGIOGRAM (21/12/2021) -CAD-RCA mid moderate stenosis

PLAN MEDICAL MANAGEMENT

C/o Retrosternal chest pain, radiating to back since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 43 years old male patient G. RAJU came with c/o retrosternal chest pain, radiating to back since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SR, MILD LV DYSFUNCTION [EF-

45%], R/F : ALCOHOLIC, CORONARY ANGIOGRAM (21/12/2021) -CAD-RCA mid moderate stenosis

PLAN MEDICAL MANAGEMENT . Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ROZAVEL 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB: CARDACE-H 2.5MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001232254

**Name**

Mr. M D  
HAMEED

**Patient Identifier**

ARHIP56214

**Age**

34Yr  
0Mth  
1Day  
s

**Sex**

Male

**Date of  
Admission**

17-  
Jun-  
2022

**Date of Discharge  
MLC No**

**Address**

JAGITIAL,Karimnagar,Telangana

**Ward/  
Bed No**

First  
Floor,  
Day  
Care,  
Bed  
no:D  
C 2

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

ATYPICAL CHEST PAIN  
MILD MR/ TR/ PAH,  
CORONARY ANGIOGRAM (17/06/2022) -CAD-Mild disease (proximal LAD ectasia  
present)

ADV: MEDICAL MANAGEMENT

C/o chest pain since 1 month

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 78/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 34 years old male patient Mr. M D HAMEED came with c/o chest pain since 1 month. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN, MILD MR/ TR/ PAH, CORONARY ANGIOGRAM (17/06/2022) -CAD-Mild disease (proximal LAD ectasia present), ADV: MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

#### DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. TONACT 40MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. NIKORAN 5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001231887

<b>Name</b>	Mr. MUTHYALA SATHAIAH
<b>Patient Identifier</b>	ARHIP56071
<b>Sex</b>	Male
<b>Age</b>	70Yr 0Mth 1Days
<b>Expired Date</b>	08-Jun-2022
<b>MLC No</b>	
<b>Address</b>	maddunoor,Karimnagar,Telangana
<b>Ward/Bed No</b>	Ground Floor, Emergency Ward, Bed no:EME6
<b>Primary Consultant Surgeons</b>	Dr. Vidya Sagar A--CARDIOLOGY
<b>Consultants Anesthesiologists</b>	

☐ **Diagnosis**

**Diagnosis**

Diseas

Disease

e	Type
---	------

CAD-ACUTE ANTERIOR WALL ST ELEVATED MI AND DKA.

C/o chest pain a/w SOB, sweatings since 1 day

AT ADMISSION:

PR: 125/min

BP: Not recordable

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 70 years old male patient Mr. MUTHYALA SATHAIAH came with c/o chest pain a/w SOB, sweatings since 1 day. All necessary investigations were done and diagnosed as CAD-ACUTE ANTERIOR WALL ST ELEVATED MI AND DKA. Poor prognosis explained to the patient attendants, suddenly patient unresponsive. INJ. Atropine and INJ. ADRENALINE given, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and ionotropic support was given. CPR started immediately, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 12.27 AM on 09/06/2022.

## CAUSE OF DEATH

-----

CARDIOPULMONARY ARREST DUE TO CAD-ACUTE ANTERIOR WALL ST ELEVATED MI AND DKA.

ARH1.0001084465

**Name**

Mr. VENKATESH  
KAMINWAR

**Patient  
Identifier**

ARHIP56221

**Age**

62Yr  
7Mth  
7Days

**Sex**

Male

**Date of  
Admission**

18-  
Jun-  
2022

**Date of  
Discharge  
MLC No**

**Address**

KARIMNAGAR.,Karimnagar,Telangana

**Ward/  
Bed No**

First  
Floor,  
Day  
Care,  
Bed  
no:DC  
3

**Primary  
Consultant**

Dr. SURESH GOUD S(MS,

PHIMOSIS  
SURGERY: CIRCUMCISSION DONE ON 18/06/2022

C/o difficulty in micturition since 1 month

PHYSICAL EXAMINATION:

ON ADMISSION

-----

Pt c/c/c

PR-81/min

BP-120/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

SPO2-98%

A 62 yrs old male patient VENKATESH KAMINWAR came with c/o difficulty in micturition since 1 month. All necessary investigations done and diagnosed as PHIMOSIS, SURGERY: CIRCUMCISION DONE ON 18/06/2022. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: AUGMENTIN 625 MG TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
2. TAB: DROLGA TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. TAB: PAN 40 MG ONCE DAILY AT 7AM FOR 5 DAYS.
4. TAB: A TO Z GOLD ONCE DAILY AT 2PM FOR 10 DAYS.
5. SYP. K-CIT 10 ml TWICE DAILY AT 8AM, 8PM

Review after 7 days in Urology OPD.



ARH1.0001226812

**Name**

Mr.  
MEDICHELIMALA  
RAJIAH

**Patient Identifier**

ARHIP55934

**Age**

50Yr  
11Mth  
29Days

**Sex**

Male

**Date of  
Admission**

30-May-  
2022

**Date of Discharge  
MLC No**

**Address**

2-49 AMBALPUR SHANKARAPATNAM  
9704704298,Telangana

**Ward/Bed No**

First  
Floor,  
MICU,  
Bed  
no:MIC  
U 4

**Primary Consultant**

DR. NIKHIL GOLI --NEUROLOGY

PCA INFARCT WITH SEPTIC SHOCK

C/o Giddiness since 1 day

Known case of hypertension diabetic mellitus

AT ADMISSION:

Afebrile

PR: 96/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft,

A 50 yr old male patient Mr. MEDICHELMALA RAJIAH came with c/o giddiness since 1 day. All necessary investigations done and diagnosed as CVA PCI STROKE, LEFT HEMIPLEGIA WITH SEPTIC SHOCK. Managed conservatively. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice. Managed with antibiotics and antiplatelets and GCS poor. Neurosurgeon consultation taken. Case of no surgical intervention patient was deteriorated and elective intubation done for prevention of aspiration and general Physician Consultation taken. Patient mild clinically improved and he was on breath and without O2 he monitoring on T- piece. Then extubated on 06/06/22 at 1 pm and patient was desaturating with 8 Ltr of 2 again re intubated on 06/06/22 at 2 p.m. ENT consultation done and plan for tracheostomy. Tracheostomy done on 10/06/22 patient on mechanical ventilator. Managed conservatively. Patient clinically improved. Now patient is stable hence patient is being discharged with required medication and advice.

Discharge Medication:

1. TAB: CLOPILET 75 MG ONCE DAILY AT 2 PM TO CONTINUE
2. TAB: STORVAS 40 MG ONCE DAILY AT 8 PM TO CONTINUE
3. TAB: BEPLEX FORTE ONCE DAILY AT 2 PM TO CONTINUE
4. TAB: PAN 40 MG ONCE DAILY AT 7 AM BBF FOR 11 DAYS

Review after 10 days in DR NIKHIL GOLI SIR OPD.

ARH1.0001146025

**Name**

Mr.  
RAMANCHA  
RAJKUMAR

**Patient Identifier**

ARHIP56217

**Age**

29Yr  
7Mth  
29Days

**Sex**

Male

**Date of  
Admission**

18-Jun-  
2022

**Date of Discharge  
MLC No**

**Address**

NTPC,Ramagundam,Telangana

**Ward/  
Bed No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:117  
B

**Primary Consultant**

DR. SRI KARAN UDDESH

ACUTE ABDOMINAL PAIN  
SECONDARY TO TRAUMA LEFT ILIAC REGION

C/o Pain in the left iliac region, following trauma to the region

AT ADMISSION:

Afebrile

PR: 86/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 29 years old male patient Mr. RAMANCHA RAJKUMAR came with above mentioned complaints. Patient diagnosed as ACUTE ABDOMINAL PAIN, SECONDARY TO TRAUMA LEFT ILIAC REGION. Treated with Inj Tramadol, Pan, Zofer. Now patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

-----

- 1) TAB. CHYMORAL FORTE THRICE DAILY AT 8AM 2PM & 8PM FOR 7 DAYS
- 2) TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 7 DAYS
- 3) TAB. ULTRACET **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001104540

**Name**

Mrs.  
RAJESHWARI  
P

**Patient Identifier**

ARHIP56139

**Age**

76Yr  
1Mth  
15Days

**Sex**

Female

**Date of Admission** 12-Jun-2022

**Date of Discharge**  
**MLC No**

**Address**

sulthanabad,Karimnagar,Telangana

**Ward/Bed No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:106  
A

**Primary Consultant**

Dr. RAMCHANDER TORREM(MD)

RIGHT URETERIC CALCULUS

SURGERY: RIGHT URSL + DJ STENTING ON 15/06/2022

C/o right flank pain, burning micturition, nausea since 15 days

K/c/o HTN

ON ADMISSION

-----

Patient c/c

Afebrile

PR-82/min

BP-120/70mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft

SPO2-99%

A 76 years old female patient Mrs. RAJESHWARI presented to hospital with c/o right flank pain, burning micturition, nausea since 15 days. All necessary investigations were done and diagnosed as RIGHT URETERIC CALCULUS, Urologist consultation taken and advised surgery, RIGHT URSL + DJ STENTING ON 15/06/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB: QCEFOR 250 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: UBLIFE ONCE DAILY AT 2PM FOR 10 DAYS
3. TAB: MULTI-8 ONCE DAILY AT 2PM FOR 10 DAYS
4. TAB: CARTBIND **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS
5. SYP. LACTIHEP 15 ml ONCE DAILY AT 8PM FOR 7 DAYS.
6. TAB: PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO NEPHROLOGY & UROLOGY OPD.

REVIEW AFTER 3 WEEKS FOR DJ STENT REMOVAL.

ARH1.0001232  
144

Name

Mr.  
NAGELLA  
JHONWESLEY

Patient  
Identifier ARHIP56178

Age 72Yr  
0Mth  
5Days

Sex Male

Date of  
Admission 14-Jun-  
2022

Expired  
Date 19-Jun-2022

MLC No

Address 41-42,RAMAKRISHNAPUR,  
MANDAMARRI,MANCHERAIL,Karimnagar,Tel  
angana

Ward/Bed No First  
Floor,  
SICU,  
Bed  
no:SIC  
U 5

Primary  
Consultant DR. SUBRAT KUMAR SOREN --  
NEUROSURGERY

Consultants

Surgeons

Anesthesiologists

☐ Cause of  
Death

Cause of Death

☐ Diagnoses

Diagnosis

[Add Diagnosis](#)

Disease	Disease Type
---------	--------------



TRAUMATIC BRAIN INJURY DIFFUSE SUBARACHNOID  
HEMORRHAGE.

Alleged to have sustained injury due to hit by Tractor while going on 2 wheeler on 13/06/2022 around 10.30 AM

Patient unresponsive state, vomiting, ENT Bleeding+

k/c/o HTN, T2DM

AT ADMISSION:

Patient **unresponsive**

PR: 96/min

BP: 150/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 95%

P/A: Soft,

GCS- E1,VT,M1

A 72 years old male patient Mr. NAGELLA JHONWESLEY came with alleged to have sustained injury due to hit by Tractor while going on 2 wheeler, patient unresponsive state, vomiting, ENT Bleeding+ . All necessary investigations were done and diagnosed as TRAUMATIC BRAIN INJURY, DIFFUSE SUBARACHNOID HEMORRHAGE. Patient was intubated and connected to mechanical ventilator support on SIMV mode with fio2-100%. CPR was initiated as per ACLS protocols, continued for 5 cycles but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 03.07 pm on 19/06/2022.

#### CAUSE OF DEATH

-----

CARDIOPULMONARY ARREST SECONDARY TO TRAUMATIC BRAIN INJURY DIFFUSE  
SUBARACHNOID HEMORRHAGE

ARH1.0001232147

		Mr. SRINIVAS RAO RACHAMADGU	
<b>Name</b>			
<b>Patient Identifier</b>	ARHIP56183	<b>Age</b>	51Yr 0Mth 5Days
<b>Sex</b>	Male	<b>Date of Admission</b>	15-Jun-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	2-40/1 THANDRIYALA,Karimnagar,Telangana	<b>Ward/ Bed No</b>	First Floor, CICU , Bed no:CICU1 0
<b>Primary Consultant</b>	Dr. KRISHNA CHAITANYA M		

CORONARY ARTERY DISEASE, AWSTEMI, EPISODE OF VT

S/P PRIMARY PTCA TO THROMBOTIC TOTAL OCCLUSION

SEVERE LV DYSFUNCTION, [LVEF- 30%]  
AW/AS AKINETIC CONTROLLED HF, SR

C/o chest pain was evaluated at Local Hospital, diagnosed to have AWSTEMI and had an episode of documented VT recovered , spontaneously reverted. He was referred here for further management

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

Mr. SRINIVAS RAO RACHAMADGU , 51 years old gentleman presented with history of chest pain was evaluated at Local Hospital, diagnosed to have AWSTMI and had an episode of documented VT recovered , spontaneously reverted. He was referred here for further management. He was taken up for primary PTCA. Coronary angiogram showed mid LAD thrombotic total occlusion. Primary PTCA to mid LAD done. TIMI-III flow. Good result. During the course of hospitalisation his sugars were controlled and renal dysfunction was managed with IV fluids and Reno-protective medication in consultation with Nephrologist and Physician. He was monitored for VT/VF episodes. His B. blockers and ivabradline dosages were adjusted. He was haemodynamically stable and symptomatically better. Hence being discharged for follow up with the following advice.

#### DISCHARGE MEDICATION:

-----

1. TAB. AXCER 90MG **TWICE IN A DAY AT 8 AM, 8 PM** TO CONTINUE.
2. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. NIKORAN 5MG **TWICE IN A DAY AT 8 AM, 8 PM** TO CONTINUE.
4. TAB. FLAVEDON MR 35MG **THRICE IN A DAY AT 8 AM 2PM & 8 PM** TO CONTINUE.
5. TAB. MET-XL 50MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. SOBINIX 500MG ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. IVABID 5 MG **TWICE IN A DAY AT 8 AM, 8 PM** TO CONTINUE.
8. TAB. RENOSAVE **TWICE IN A DAY AT 8 AM, 8 PM** TO CONTINUE.
9. TAB. FRUSELAC-DS **TWICE IN A DAY AT 8 AM, 8 PM** TO CONTINUE.
10. TAB. KETOCHECK **TWICE IN A DAY AT 8 AM, 8 PM** TO CONTINUE.

DIABETIC DIET AS ADVISED NUTRITIONIST  
DIABETIC MEDICATION AS ADVISED BY PHYSICIAN

REVIEW ON 28/06/2022 (TUESDAY) WITH CBC, RP-II, FCP & ECG REPORTS TO CARDIAC  
OPD

ARH1.0001232045

**Name**

Mr. N  
SRIDHAR

**Patient Identifier**

ARHIP56142

**Age**

35Yr  
0Mth  
7Days

**Sex**

Male

**Date of  
Admission**

13-Jun-  
2022

**Date of Discharge**  
**MLC No**

**Address**

ITKAYALA RAIKAL  
JAGITIAL,Karimnagar,Telangana

**Ward/  
Bed No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:118  
A

**Primary Consultant**

Dr Chandra Shekar Sathineni

## ACUTE PANCREATITIS

C/o constipation, multiple episodes of vomitings, generalised weakness since 1 day  
History of epigastric pain since 3-4 days  
Known case of chronic alcoholic

### AT ADMISSION:

Afebrile

PR: 85/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft,

A 35 years old male patient SRIDHAR came with c/o constipation, multiple episodes of vomitings, generalised weakness since 1 day, history of epigastric pain since 3-4 days, Known case of chronic alcoholic. All necessary investigations were done and diagnosed as ACUTE PANCREATITIS. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. FPM-ACT TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
2. TAB. LINOZEM 600 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
3. TAB. RAZO-D ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.
4. TAB. HEADNEURON ONCE DAILY AT 2PM FOR 10 DAYS
5. GLUTUP SACHETS ONCE DAILY AT 8AM WITH GLASS OF WATER FOR 10 DAYS.

Review after 7 days in General Medicine OPD.

ARH1.0001231527

**Name**

Mr. SUDHEER  
KALLEPALLY

**Patient  
Identifier**

ARHIP56154

**Age**

40Yr  
0Mth  
21Days

**Sex**

Male

**Date of  
Admission**

13-Jun-  
2022

**Date of  
Discharge  
MLC No**

**Address**

1-  
84,paddapalli,karimnagr,Karimnagar,Tela  
ngana

**Ward/  
Bed No**

Secon  
d  
Floor,  
Semi  
Private  
, Bed  
no:123  
B

**Primary  
Consultant**

Dr. RAMCHANDER TORREM(

AKI

C/o fever, dysurea, generalized weakness since 2 days

AT ADMISSION:

PR: 84/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 40 years old male patient Mr. SUDHEER KALLEPALLY came with c/o fever, dysurea, generalized weakness since 2 days. All necessary investigations were done and diagnosed as AKI. Managed conservatively. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB. LINOZEM 600 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
2. TAB. SOBINIX-DS ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. DYTOR 10 MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. METOZ 5 MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. CARDIVAS 12.5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. MOXOVAS 0.3 MG **THRICE IN A DAY AT 8 AM, 2PM & 8 PM** TO CONTINUE.
7. TAB. ZEROZ LP **THRICE IN A DAY AT 8 AM, 2PM & 8 PM** TO CONTINUE.
8. TAB. WYSOLONE 10 MG ONCE DAILY AT 2PM TO CONTINUE.
9. TAB. ZOLFRESH 5 MG ONCE DAILY AT 8PM TO CONTINUE.
10. TAB. PANTOCID 40 MG ONCE DAILY AT 7 AM BBF FOR 7 DAYS

REVIEW AFTER 11 DAYS IN NEPHROLOGY OPD



ARH1.0001186579

**Name**

Mrs. L MAMATHA

**Patient Identifier**

ARHIP56157

**Age**

29Yr  
1Mth  
17Days

**Sex**

Female

**Date of Admission**

13-Jun-2022

**Date of Discharge**  
**MLC No**

**Address**

NAGNOOR,Karimnagar,Telangana

**Ward/ Bed No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:108  
A

**Primary Consultant**

Dr. RAMCHANDER TORREM

IGA NEPHROPATHY  
CGN-CKD

C/o Vomiting, nausea since 2 days

Known case of IGA NEPHROPATHY, CGN-CKD

S/P AV fistula not working

AT ADMISSION:

PR: 80/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 29 years old female patient Mrs. MAMATHA came with c/o Vomiting, nausea since 2 days. All necessary investigations were done and diagnosed as IGA NEPHROPATHY, CGN-CKD. Managed conservatively. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB. FPM-ACT 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
2. TAB. SOBINIX-DS **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. ZEROZ LP **THRICE IN A DAY AT 8 AM, 2PM & 8 PM** TO CONTINUE.
4. TAB. MULTI-8 ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. CALCI CZ ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. PROLOMET-XL 50 MG ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. UBILIFE ONCE DAILY AT 2PM TO CONTINUE.
8. SYP. LACTIHEP 2 tsp ONCE DAILY AT 9 P.M.

REVIEW AFTER 11 DAYS IN NEPHROLOGY OPD

ARH1.0001232218

**Name**

Mrs.  
BHOODEVI  
K

**Patient Identifier**

ARHIP56203

**Age**

56Yr  
0Mth  
4Days

**Sex**

Female

**Date of  
Admission**

16-Jun-  
2022

**Date of Discharge  
MLC No**

**Address**

kothapalli  
( haveli ),Karimnagar,Telangana

**Ward/  
Bed No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:103  
C

**Primary Consultant**

Dr. RAMCHANDER TORREM(MD  
(General

AKI  
DIABETIC MELLITUS  
HYPERTENSION

C/o Shortness of breath, chest pain, bilateral pedal oedema since 2 days

AT ADMISSION:

PR: 80/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft

A 56 years old female patient Mrs. BHOODEVI K came with c/o shortness of breath, chest pain, bilateral pedal oedema since 2 days. All necessary investigations were done and diagnosed as AKI, DIABETIC MELLITUS, HYPERTENSION. Managed conservatively. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB. FAROALFA 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
2. TAB. SOBINIX-DS ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ROSA GOLD MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. UBILIFE ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. MULTI-8 ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. RECLIDE XR 30 MG ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 11 DAYS IN NEPHROLOGY OPD

ARH1.0001232171

**Name**

Mr. CHENNURI  
PULLAIAH

**Patient  
Identifier**

ARHIP56186

**Age**

70Yr  
0Mth  
5Days

**Sex**

Male

**Date of  
Admission**

15-Jun-  
2022

**Date of  
Discharge  
MLC No**

**Address**

18-1-95, ADDAGUNTAPALLI,  
GODAVARIKANI, PEDDAPALLI, Karimnagar, Telangana

**Ward/  
Bed No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:122  
B

**Primary  
Consultant**

DR. SRI KARAN UDDESH --

URINARY TRACT INFECTION  
PARKINSON DISEASE

C/o fever with chills, burning micturition since 3 days

Chronic alcoholism, diabetic mellitus

AT ADMISSION:

PR: 100/min

BP: 140/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 100%

P/A: Soft,

A 70 years old male patient Mr. CHENNURI PULLAIAH came with above mentioned complaints, patient presented with the above-mentioned complaints patient was diagnosed to have urinary tract infection and was started on INJ. LEVOFLOXACIN and other supportive treatment. On the second day of hospitalisation the patient was observed to have a pill rolling tremor and was having history of bradykinesia and on examination had mild cogwheel rigidity. An MRI brain was done which revealed lacunar infarcts, report has been enclosed. The patient was symptomatically better and is hence being discharged with following advice.

DISCHARGE MEDICATION:

-----

- 1) TAB. SYNDOPA PLUS ½ TAB THRICE DAILY AT 8AM 2PM & 8PM FOR 7 DAYS
- 2) TAB. THIAMINE 100 MG ONCE DAILY AT 2PM FOR 7 DAYS
- 3) TAB. NEURIT CD3 ONCE DAILY AT 8AM FOR 7 DAYS
- 4) TAB. OXAZEPAM 15 MG ONCE DAILY AT 8PM FOR 7 DAYS
- 5) SYP. LACTIFIBRE 15 ml ONCE DAILY AT 9 P.M.
- 6) TAB. TELMA 20 MG ONCE DAILY AT 8AM FOR 7 DAYS
- 7) TAB. VELDA-M 50/1000 **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS
- 8) TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 7 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001232117

**Name**

Mr.  
BHOOMAIA  
H G

**Patient Identifier**

ARHIP56187

**Age**

62Yr  
0Mth  
6Days

**Sex**

Male

**Date of Admission** 15-Jun-2022

**Date of Discharge  
MLC No**

**Address**

THEEGALAGUTTAPALLI,Karimnagar,Telangan  
a

**Ward/Bed  
No**

Second  
Floor,  
Male  
General Ward,  
Bed  
no:GW  
22

**Primary Consultant**

Dr. KRISHNA CHAITANYA M --CARDIOLOGY

CORONARY ARTERY DISEASE, AWTMI, FAIR LV FUNCTION, NO HF, SR

LAD MID 95% STENOSIS

PTCA TO LAD [2 STENTS]

GOOD RESULT

C/o chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 73/min

BP: 90/50mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft

A 62 years old Mr. BHOOMAIAH presented with history of chest pain was evaluated and coronary angiogram done showed proximal to mid long segment LAD disease with maximum severity of 95% stenosis. PTCA to LAD with 2 stents [Metafor 3.0 x 16 mm, Metafor 2.75 x 37 mm] done. Good result. His medication were optimized. He is symptomatically better and haemodynamically stable, hence being discharged with following advice.

DISCHARGE MEDICATION:

-----

1. TAB. AXCER 90MG **TWICE IN A DAY AT 8 AM, 8 PM** TO CONTINUE.
2. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 80 MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS
5. TAB. NIKORAN 5 MG ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. FLAVEDON MR 35MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. MET-XL 50MG ONCE DAILY AT 8AM TO CONTINUE.
8. TAB. NITROCONTIN 2.6 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
9. TAB. OROFER XT ONCE DAILY AT 8AM TO CONTINUE.

DIABETIC DIET AS ADVISED NUTRITIONIST  
DIABETIC MEDICATION AS ADVISED BY PHYSICIAN

REVIEW ON 28/06/2022 (TUESDAY) WITH CBC, RP-II & ECG REPORTS TO CARDIAC OPD



ARH1.0001232156

		<b>Name</b>	Mr. GARGULA CHANDRAREDDY	
<b>Patient Identifier</b>	ARHIP56184	<b>Age</b>	64Yr 5Mth 5Days	
<b>Sex</b>	Male	<b>Date of Admission</b>	15-Jun-2022	
<b>Date of Discharge</b>				
<b>MLC No</b>				
<b>Address</b>	1-66, RAMANNAPET,Sircilla,Telangana		<b>Ward/Bed No</b>	Second Floor, Male General Ward, Bed no:GW 12
<b>Primary Consultant</b>	Dr. KRISHNA CHAITANYA			

CORONARY ARTERY DISEASE, AWMi, MILD LV DYSFUNCTION,

S/P: PTCA TO LAD OSTIAL [4 X 16 mm stent]

NO HF, SR

C/o chest pain since 4 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 80/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 64 years old Mr. GARGULA CHANDRAREDDY patient presented with complaint of chest pain ECG showed AW ST-T changes. Coronary angiogram done which showed ostial LAD 80% stenosis PTCA to LAD done with 4 x 16 mm stent. He was symptom free post procedure. He is symptomatically better. Hence being discharged with following advice.

DISCHARGE MEDICATION:

-----

1. TAB. AXCER 90MG **TWICE IN A DAY AT 8 AM, 8 PM** TO CONTINUE.
2. TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 80 MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS
5. TAB. MET-XL 50MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. RAMISTAR 2.5 MG ONCE DAILY AT 2PM TO CONTINUE.

DIABETIC DIET AS ADVISED NUTRITIONIST  
DIABETIC MEDICATION AS ADVISED BY PHYSICIAN

REVIEW ON 28/06/2022 (TUESDAY) WITH CBC, RP-II & ECG REPORTS TO CARDIAC OPD

ARH1.0001232125

**Name**

Mr. M  
VENKAIAH

**Patient Identifier**

ARHIP56180

**Age**

72Yr  
0Mth  
6Days

**Sex**

Male

**Date of  
Admission**

14-Jun-  
2022

**Date of Discharge  
MLC No**

**Address**

KAGAZNAGAR,Telangana

**Ward/  
Bed No**

Second  
Floor,  
Male  
General Ward,  
Bed  
no:GW  
20

**Primary Consultant**

Dr. SURESH GOUD

RIGHT RENAL CALCULUS

RIGHT PCNL+DJ STENTING DONE ON 15.06.2022

C/o Right loin pain, burning micturition since 7 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

All required investigations done and enclosed

A 72 yrs old male patient VENKAIAH came to the hospital with c/o right loin pain, burning micturition since 7 days. All necessary investigations done and diagnosed as RIGHT RENAL CALCULUS, RIGHT PCNL+DJ STENTING DONE ON 15.06.2022. Post operative period was uneventful. Patient symptomatically improved, Patient is being discharged in haemodynamically stable condition with required medication and advice. Patient explained for stent removal after 3 weeks.

#### DISCHARGE MEDICATION:

-----

1. TAB: CIFRAN 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: FAMOCID 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: A TO Z ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO UROLOGY OPD, STENT REMOVAL AFTER 3 WEEKS

ARH1.0001128973

**Name**

Mr. PARKALA  
ANJIAH

**Patient  
Identifier**

ARHIP56239

**Age**

46Yr  
2Mth  
3Day  
s

**Sex**

Male

**Date of  
Admission**

20-  
Jun-  
2022

**Date of  
Discharge  
MLC No**

**Address**

THIPPAPURAM,Karimnagar,Telangana

**Ward/  
Bed No**

First  
Floor,  
Day  
Care,  
Bed  
no:D  
C 1

**Primary  
Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

ATYPICAL CHEST PAIN WITH ECG CHANGES  
CORONARY ANGIOGRAM (20/06/22) PATENT STENT IN LAD  
K/C/O CAD -AWMI PRIMARY PTCA TO LAD ON 17/04/2017  
R/F HYPERTENSION  
ADV: MEDICAL MANAGEMENT

C/o Chest pain radiating to back since 2 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 46 years old male patient PARKALA ANJIAH came with c/o Chest pain radiating to back since 2 days. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN WITH ECG CHANGES  
CORONARY ANGIOGRAM (20/06/22) PATENT STENT IN LAD, K/C/O CAD -AWMI PRIMARY PTCA TO LAD ON 17/04/2017, R/F HYPERTENSION, ADV: MEDICAL MANAGEMENT . Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. ROSAGOLD ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. PROLOMET R 25 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. PAN-D 40 MG ONCE IN A DAY AT 7 A.M. BBF FOR 10 DAYS
4. SYP. POTKLOR 10 ML THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 2 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001232146

**Name**

Mr.  
SWAMIDAS  
MYSADARI

**Patient Identifier** ARHIP56179

**Age** 52Yr  
0Mth  
6Days

**Sex** Male

**Date of Admission** 14-Jun-2022

**Date of Discharge**  
**MLC No**

**Address** 5-88  
GOLLAPALLY,Karimnagar,Telangana

**Ward/ Bed No** Second Floor,  
Male General Ward,  
Bed no:GW17

**Primary Consultant** Dr. RAMCHANDER TORREM(MD)

CHRONIC KIDNEY DISEASE

C/o Shortness of breath, swelling of feet, decreased appetite

AT ADMISSION:

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 52 years old male patient Mr. SWAMIDAS MYSDADARI came with c/o Shortness of breath, swelling of feet, decreased appetite. All necessary investigations were done and diagnosed as CHRONIC KIDNEY DISEASE, 4 sessions of haemodialysis done . Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB. CEFURAZ-CV TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
2. TAB. DYTOR 10 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. GEROZ-LP THRICE DAILY AT 8AM 2PM 8PM TO CONTINUE.
4. TAB. MULTI-8 ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. METOZ ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. CALCI-OZ ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 11 DAYS IN NEPHROLOGY OPD



ARH1.0001232054		<b>Name</b>	Mr. THOOM RAMAIAH
<b>Patient Identifier</b>	ARHIP56149	<b>Age</b>	76Yr 5Mth 7Days
<b>Sex</b>	Male	<b>Date of Admission</b>	13-Jun-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	1-78, WALLAMPAHAD,Karimnagar,Telangana	<b>Ward/Bed No</b>	Second Floor, Male General Ward, Bed no:GW 14
<b>Primary Consultant</b>	Dr. Iftekarali (MS)		

INTRACAPSULAR FRACTURE NECK OF FEMUR LEFT

SURGERY: AMP LEFT HIP DONE ON 15/06/2022

Alleged to have sustained injury due to slip and fall at home, sustained injury to left leg

PHYSICAL EXAMINATION:

ON ADMISSION

-----  
afebrile  
PR-84/min  
BP-120/80mmhg  
RR-20/min  
RS-BAE+  
CVS-S1S2+  
P/A-Soft  
SPO2-99%

A 76 years old male patient Mr. THOOM RAMAIAH came with alleged to have sustained injury due to slip and fall at home, sustained injury to left leg . All necessary investigations were done and diagnosed as INTRACAPSULAR FRACTURE NECK OF FEMUR LEFT, SURGERY: AMP LEFT HIP DONE ON 15/06/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence she is being discharged with required medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB. TROVFIZ 500MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
2. TAB. VOVERAN 75MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
3. TAB. KYCID—RD ONCE DAILY AT 2PM FOR 11 DAYS.
4. TAB. OCTOCAL ONCE DAILY AT 2PM FOR 11 DAYS.

REVIEW AFTER 11 DAYS TO DR. IFTEKARALI SIR OPD.

ARH1.0001231831

**Name**

Mr. R  
MONDAIAH

**Patient Identifier**

ARHIP56136

**Age**

55Yr  
0Mth  
12Days

**Sex**

Male

**Date of Admission**

12-Jun-2022

**Date of Discharge  
MLC No**

**Address**

marripelli,vemulawada,Sircilla,Telangana

**Ward/  
Bed No**

First  
Floor,  
CT  
POST,  
Bed  
no:CT  
5

**Primary Consultant**

Dr SOMASHEKAR  
K(MS,MCH(CTVS),Consultant-Cardio  
Thoracic & Vascular Surgeon)--C T  
SURGERY

CORONARY ARTERY DISEASE + LMCA+TRIPLE VESSEL DISEASE + LV  
DYSFUNCTION+ S/P AWTMI+DM+HTN

SURGERY - CORONARY ARTERY BYPASS GRAFTING [SVG TO OM, PDA] DONE  
ON 15/06/2022.

C/o retrosternal chest pain a/w sweating since 1 day

K/c/o T2DM, HTN

ON ADMISSION VITAL

-----

Patient conscious, coherent

Afebrile

PR-80/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 55 years old male patient Mr. MONDAIAH presented to hospital with c/o retrosternal chest pain a/w sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE + LMCA+TRIPLE VESSEL DISEASE + LV DYSFUNCTION+ S/P AWTMI+DM+HTN, SURGERY - CORONARY ARTERY BYPASS GRAFTING [SVG TO OM, PDA] DONE ON 15/06/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, PARADOXICAL SEPTAL MOTION, MODERATE LV DYSFUNCTION, NO PE/CLOT/VEG, EF-55%

BMI is \_\_\_\_ kg/m<sup>2</sup>.

Sr. Creatinine report on 16.06.2022 1.0 mg/dl.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. ND-VIT ONCE DAILY AT 2PM TO CONTINUE.
- 4) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. CARDARONE 200 MG THRICE DAILY AT 8AM 2PM 8PM TO CONTINUE.
- 5) TAB. TRAMADOL 50 MG THRICE DAILY AT 8AM 2PM 8PM FOR 5 DAYS
- 6) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.
- 7) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.
- 8) TAB. ZETAGLIM MV2 **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 9) TAB. EOSHINE MR **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 10) TAB. BACLOFSIN THRICE **IN A DAY AT 8 AM 2PM 8 PM** TO CONTINUE.

REVIEW AFTER 11 DAYS TO CTVS OPD

ARH1.0001230547

**Name**

Mr.  
SATHIAIAH  
BURRA

**Patient Identifier**

ARHIP56208

**Age**

69Yr  
1Mth  
16Days

**Sex**

Male

**Date of  
Admission**

17-Jun-  
2022

**Date of Discharge  
MLC No**

**Address**

TANGALLAPALLY,  
KOHEDA,,Siddipet,Telangana

**Ward/  
Bed No**

First  
Floor,  
MICU,  
Bed  
no:MIC  
U 3

**Primary Consultant**

DR. SANJAY KUMAR KAMINWAR

ACUTE LEFT PCA INFARCTION  
INFERIOR WALL MI  
AKI

C/o drooping of left eyelid  
H/o dyspnea, vomiting, fever since 4 days

AT ADMISSION:

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 69 years old male patient Mr. SATHIAIAH BURRA came with c/o drooping of left eyelid, h/o dyspnea, vomiting, fever since 4 days. All necessary investigations were done and diagnosed as ACUTE LEFT PCA INFARCTION, INFERIOR WALL MI, AKI. Managed conservatively. Cardiologist consultation taken and advised, coronary angiogram, CAG not done due to increase in creatinine. Nephrologist consultation taken and advice followed. Poor prognosis explained to the patient attendants, Patient attendants requested for discharge, hence patient is being discharge at request.

DISCHARGE MEDICATION:

-----

- 1) TAB. PREVA AS 75 MG ONCE DAILY AT 2PM FOR 7 DAYS
- 2) TAB. ATCOR 40 MG ONCE DAILY AT 9PM FOR 7 DAYS
- 3) TAB. KETOCHECK **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS
- 4) TAB. CUDCE **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS
- 5) TAB. FEBUGET ONCE DAILY AT 2PM FOR 7 DAYS

REVIEW AFTER 7 DAYS IN DR SANJAY KUMAR SIR OPD

ARH1.0001232355

**Patient Identifier** ARHIP56256

**Sex** Male

**Date of Discharge**  
**MLC No**

**Address** KALYANIKHANI,MANDAMARRI,MANCHERIAL,Adilabad(Adilabad),Telan  
gana

**Primary Consultant** Dr. KRISHNA CHAITANYA M --

**Name** Mr. VENU  
GOPAL  
KORE

**Age** 35Yr  
0Mth  
1Days

**Date of Admission** 20-Jun-  
2022

**Ward/Bed No** First  
Floor,  
HDU,  
Bed  
no:HD  
U 1

S

CORONARY ARTERY DISEASE- UNSTABLE ANGINA.

CORONARY ANGIOGRAM DONE ON 20/06/2022- CAD-LAD -ECTATIC CORONARIES WITH SLOW FLOW

PLAN:MEDICAL MANAGEMENT

C/o left sided chest pain since 1 day

H/o numbness and tingling sensation in both upper limbs

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 58/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft



A 35 years old male patient Mr. VENU GOPAL KORE came with c/o left sided chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE- UNSTABLE ANGINA.  
CORONARY ANGIOGRAM DONE ON 20/06/2022- CAD-LAD -ECTATIC CORONARIES WITH SLOW FLOW, PLAN:MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. NIKORAN 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
2. TAB. ECOSPRIN-AV 75 MG/10 ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. FLAVEDAN MR 35MG THRICE DAILY AT 8AM 2PM 8PM TO CONTINUE.
4. TAB. PAN 40MG ONCE DAILY AT 7AM BBF FOR 10 DAYS.
5. TAB. ANXIT 0.25 MG ONCE DAILY AT 9 PM FOR 10 DAYS.

REVIEW ON 21/06/2022 TO CARDIAC OPD

ARH1.0001232303

**Name**

Mrs. NARSU  
BAI GONE

**Patient  
Identifier**

ARHIP56238

**Age**

102Yr  
0Mth  
1Days

**Sex**

Female

**Date of  
Admission**

20-Jun-  
2022

**Date of  
Discharge**

**MLC No**

**Address**

BOYAWADA, KORUTLA,  
JAGITIAL, Karimnagar, Telanga  
na

**Ward/  
Bed No**

First  
Floor,  
MICU,  
Bed  
no: MIC  
U 3

**Primary  
Consultant**

Dr Chandra Shekar Sathineni

UPPER GI BLEED  
? APD  
ANAEMIA

Patient presented with c/o fever since 1 day a/w blood vomitings 6 episodes,

AT ADMISSION:

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 102 years old female patient Mrs. NARSU BAI GONE came with c/o fever since 1 day associated with blood vomitings 6 episodes. All necessary investigations were done and diagnosed as UPPER GI BLEED, ? APD, ANAEMIA. Managed conservatively. 2 units of PCV transfusion given in view of anaemia. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA.

ARH1.0001232185		<b>Name</b>	Mrs. PRAMEELA ELUGAM
<b>Patient Identifier</b>	ARHIP56197	<b>Age</b>	56Yr 0Mth 6Days
<b>Sex</b>	Female	<b>Date of Admission</b>	16-Jun- 2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	2-7-1099 F CLONY,Adilabad(Adilabad),Telangana	<b>Ward/ Bed No</b>	First Floor, CICU , Bed no:CICU1 1
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE IWMI

MODERATE LV DYSFUNCTION, EF-37%

CORONARY ANGIOGRAM DONE ON 18/06/2022 – CAD-SVD (RCA)

PTCA+DES TO RCA 2 STENTS WITH 3.0 X 19 MM METAFOR TO MID RCA, 3.0 X 13 MM METAFOR TO PROXIMAL RCA DONE ON 16/10/2021

C/o Retrosternal chest pain radiating to back since 1 day

AT ADMISSION:

Afebrile

PR: 80/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 56years old female patient Mrs. PRAMEELA ELUGAM came with c/o retrosternal chest pain radiating to back since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, MODERATE LV DYSFUNCTION, EF-37%, CORONARY ANGIOGRAM DONE ON 18/06/2022 – CAD-SVD (RCA), PTCA+DES TO RCA 2 STENTS WITH 3.0 X 19 MM METAFOR TO MID RCA, 3.0 X 13 MM METAFOR TO PROXIMAL RCA DONE ON 16/10/2021. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPITAB 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. ELTROXIN 25 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. CILODOC 50 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001232186

**Name**

Mr. D  
GANGAIAH

**Patient Identifier**

ARHIP56198

**Age**

72Yr  
0Mth  
5Days

**Sex**

Male

**Date of Admission**

16-Jun-2022

**Date of Discharge**  
**MLC No**

**Address**

CHAMANAPALLI,Karimnagar,Telangana

**Ward/Bed No**

First  
Floor,  
CICU ,  
Bed  
no:CICU  
9

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, AWTMI

MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%

CORONARY ANGIOGRAM DONE ON 18/06/2022 - CAD-SVD (LAD) & RCA Ectesia

PTCA+DES TO LAD WITH 3.0 X 16 MM METAFOR DONE ON 18/06/2022

R/F: DENOVO HTN

C/o Retrosternal chest pain, radiating to back since 1 day

AT ADMISSION:

Afebrile

PR: 102/min

BP: 160/100mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 72years old male patient Mr. GANGAIAH came with c/o retrosternal chest pain, radiating to back since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWTMI, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%, R/F: DENOVO HTN, CORONARY ANGIOGRAM DONE ON 18/06/2022 - CAD-SVD (LAD) & RCA Ectesia, PTCA+DES TO LAD WITH 3.0 X 16 MM METAFOR DONE ON 18/06/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPITAB 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. RAMISTAR 2.5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 5) TAB. BETALOC 50 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 6) TAB. CILODOC 50 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 7) TAB. FRUSELAC ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.



--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001178468

**Name**

Mr.  
CHENNAMANENI  
SUGUNAKAR  
RAO

**Patient Identifier**

ARHIP56241

**Age**

55Yr 2Mth  
1Days

**Sex**

Male

**Date of  
Admission**

20-Jun-  
2022

**Date of Discharge**

**MLC No**

**Address**

9-4-222,SRINAGAR  
COLONY,SAPTHAGIRI  
COLONY,Karimnagar,Telangana

**Ward/Bed No**

First Floor,  
RECOVERY  
ROOM, Bed  
no:RR 3

**Primary Consultant**

Dr. GOUTHAM ROY (MS)

GRADE-III INTERNAL HEMORRHOIDS  
SURGERY: STAPLER HEMORRHOIDECTOMY DONE ON 20/06/2022

C/o pain and bleeding per rectum since 10 days

PHYSICAL EXAMINATION:

ON ADMISSION

-----

Pt c/c/c

afebrile

PR-82/min

BP-110/70mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

SPO2-100%

A 55 yrs old male patient Mr. CHENNAMANENI SUGUNAKAR RAO came with c/o pain and bleeding per rectum since 10 days. All necessary investigations done and diagnosed as GRADE-III INTERNAL HEMORRHOIDS, SURGERY: STAPLER HEMORRHOIDECTOMY DONE ON 20/06/2022. Findings: Multiple internal hemorrhoids noted @ 3'O, 7'O & 11'O clock in position. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. SYP. LACTIHEP 3 TSP ONCE IN A DAY AT 8 PM
4. XYLOCAINE JELLY EVERY 4<sup>th</sup> hrly
5. SITZ BATH
6. METROGYL-P OINTMENT L/A THRICE DAILY AT 8AM 2PM 8PM
7. GLUTAVULT SACHETS ONCE DAILY AT 8AM WITH GLASS OF WATER FOR 15 DAYS.

Review after 7 days in General Surgery OPD.

ARH1.0001232256

**Name**

Mr.  
NARAYANA  
KONDAPALLI

**Patient Identifier**

ARHIP56216

**Age** 47Yr 0Mth  
4Days

**Sex**

Male

**Date of Admission** 18-Jun-2022

**Date of Discharge**  
**MLC No**

**Address**

6-53/3 CHEERAL  
VANCHA,Karimnagar,Telangana

**Ward/Bed No**

First  
Floor,  
CICU ,  
Bed  
no:CICU1  
3

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE , ACUTE AWM

MODERATE LV DYSFUNCTION, EF-40%

S/P CORONARY ANGIOGRAM DONE ON 20/06/2022 - CAD-DVD [LAD, RCA]

PLAN CABG.

R/F HTN, T2DM

C/o Retrosternal chest pain, non radiating since 1 day

At Admission

Afebrile

PR: 82/min

BP: 120/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-98%

A 47 years old male patient Mr. NARAYANA KONDAPALLI came with c/o retrosternal chest pain, non radiating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , ACUTE AWMI, MODERATE LV DYSFUNCTION, EF-40%, S/P CORONARY ANGIOGRAM DONE ON 20/06/2022 - CAD-DVD [LAD, RCA], PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPITAB 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. BETALOC 50 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. RAMISTAR 2.5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. AMARYL 1 MG ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS IN CARDIAC OPD

ARH1.0001232085

**Name**

Ms. D  
VARSHINI

**Patient Identifier**

ARHIP56209

**Age**

9Yr  
0Mth  
8Days

**Sex**

Female

**Date of  
Admission**

17-Jun-  
2022

**Date of Discharge  
MLC No**

**Address**

KORUTLA,Karimnagar,Telangana

**Ward/  
Bed No**

Second  
Floor,  
Female  
General  
Ward,  
Bed  
no:GW  
6

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

ACHD, OS-ASD, L - R SHUNT

S/P DEVICE CLOSURE DONE ON 20/06/2022

DEVICE MALALINED, NO FLOW ACROSS THE SEPTUM

PLAN: SURGICAL CLOSURE OF ASD

C/o left sided chest pain since 3 months

H/o giddiness

AT ADMISSION:

Afebrile

PR: 96/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft



A 9 years old female patient Ms. D. VARSHINI came with c/o left sided chest pain since 3 months. All necessary investigations were done and diagnosed as ACHD, OS-ASD, L - R SHUNT, S/P DEVICE CLOSURE DONE ON 20/06/2022, DEVICE MALALINED, NO FLOW ACROSS THE SEPTUM, PLAN: SURGICAL CLOSURE OF ASD. Patient is being discharged in hemodynamically stable condition with required medication and advise.

REVIEW AFTER 11 DAYS IN CARDIAC OPD



ARH1.0001232257

**Name**

Mrs. A  
VAJARAMMA

**Patient Identifier**

ARHIP56218

**Age**

81Yr  
0Mth  
3Days

**Sex**

Female

**Date of Admission**

18-Jun-2022

**Date of Discharge**

21-Jun-2022

**MLC No**

**Address**

BOIWADA  
KARIMNAGAR, Karimnagar, Telangana

**Ward/Bed No**

First  
Floor,  
MICU,  
Bed  
no: MIC  
U 1

**Primary Consultant**

DR. SRI KARAN UDDESH --INTERNAL  
MEDICINE

SEPSIS WITH MODS

AKI

SHOCK

C/o fever, vomitings, loose stools since 1 day

K/c/o HTN, Dyslipidemia

AT ADMISSION:

PR: 110/min

BP: 50/30mmHg

RS: B/l crackles, decreased air

CVS: S1S2

RR: 24/min

SPO2: 95% 6L/min

P/A: Soft

A 81 years old female patient Mrs. A VAJARAMMA presented with the above-mentioned complaints, on initial examination patient had profound hypotension 1 L NS fluid challenge was given. Following which the BP improved to 80/60 mmHg then patient was started on inotropic support. The patient was started on INJ. MEROPENEM and INJ. TEICOPLANIN, blood cultures and urine cultures were sent, reports are pending. The Sr. Procalcitonin was 81.6 pg per mL. Patient required oxygen via nasal prongs at 4 L/min now it has decreased to 2 L/min. The patient is clinically better since admission. The patient requires further hospitalisation but attenders are unwilling hence patient is being discharged against medical advice

ARH1.0001232111

**Name**

Mr.  
KOMARAIHA  
A

**Patient Identifier**

ARHIP56168

**Age**

64Yr  
4Mth  
11Days

**Sex**

Male

**Date of  
Admission**

14-Jun-  
2022

**Date of Discharge**  
**MLC No**

**Address**

SURVERY NO 52, BACK SIDE OF LADDA  
RICE MILL, GADDERAGADI,  
MANCHERIAL, Telangana

**Ward/Bed  
No**

First  
Floor,  
SICU,  
Bed  
no: SICU  
2

**Primary Consultant**

Dr. SURESH GOUD S(MS,M.Ch

LEFT EPIDIDYMO ORCHITIS  
SURGERY: CYSTOSCOPY DONE 20/06/2022

C/o pain, swelling in the left groin, scrotum since 5 days  
Pain in the right groin scrotum since 3 days

## ON ADMISSION

-----

Patient c/c

PR-102/min

BP-100/60mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft

SPO2-96%

A 64 years old male patient KOMARAI AH presented to hospital with c/o pain, swelling in the left groin, scrotum since 5 days, pain in the right groin scrotum since 3 days. All necessary investigations were done and diagnosed as LEFT EPIDIDYMO ORCHITIS, SURGERY: CYSTOSCOPY DONE 20/06/2022. Post operative period was uneventful. Neuro physician consultation taken and advice followed. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB: ROXSAFE 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: PAN-D 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: A TO Z GOLD ONCE DAILY AT 2PM FOR 10 DAYS
5. TAB: URIMAX ONCE DAILY AT 8 PM FOR 7 DAYS.
6. CAP: LUMIA D3 60K ONCE IN A WEEK FOR 1 MONTH
7. TAB: SHELCAL-XT ONCE DAILY AT 2 PM FOR 10 DAYS.

REVIEW AFTER 7 DAYS TO UROLOGY OPD.

56236

ARH1.0001232301

<b>Name</b>	Mr. SURYA NARAYANA T		
<b>Patient Identifier</b>	ARHIP56236	<b>Age</b>	75Yr 0Mth 4Days
<b>Sex</b>	Male	<b>Date of Admission</b>	19-Jun-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	12-678,Adilabad(Adilabad),Telangana	<b>Ward/ Bed No</b>	First Floor, CICU , Bed no:CICU 2
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY		

COMPLETE HEART BLOCK WITH CORONARY ARTERY DISEASE, ACUTE IWMI

NORMAL LV SYSTOLIC FUNCTION, EF 56%

TPI DONE ON 19/06/2022

CORONARY ANGIOGRAM DONE ON 19/06/2022 - CAD-SVD (RCA)

PTCA+DES TO RCA WITH 3.0 X 32 MM METAFOR DONE ON 19/06/2022

R/F: HTN

C/o chest pain since 1 day associated with sweating

AT ADMISSION:

Afebrile

PR: 92/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 75years old male patient Mr. SURYA NARAYANA came with c/o chest pain since 1 day associated with sweating. All necessary investigations were done and diagnosed as COMPLETE HEART BLOCK WITH CORONARY ARTERY DISEASE, ACUTE IWMI, NORMAL LV SYSTOLIC FUNCTION, EF 56%, TPI DONE ON 19/06/2022, CORONARY ANGIOGRAM DONE ON 19/06/2022 - CAD-SVD (RCA), PTCA+DES TO RCA WITH 3.0 X 32 MM METAFOR DONE ON 20/06/2022 [LOT NO: MH42, S/N :CM32MH42043]. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPITAB 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. CILODOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 4) TAB. STORVAS 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. LIPRIL 5 MG ONCE DAILY AT 8AM TO CONTINUE.
- 6)TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.
- 7)SYP. POTKLOR 10 ML THRICE DAILY AT 8AM, 2PM, 8PM FOR 2 DAYS.

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001232393

**Name**

Mrs.  
VIJAYA  
LAXMI

**Patient Identifier**

ARHIP56264

**Age**

60Yr 0Mth  
2Days

**Sex**

Female

**Date of  
Admission**

21-Jun-  
2022

**Date of Discharge  
MLC No**

**Address**

Godavarikhani  
Peddapalli,Ramagundam,Telangana

**Ward/  
Bed No**

First  
Floor,  
CICU ,  
Bed  
no:CICU1  
3

**Primary Consultant**

Dr. KRISHNA CHAITANYA M

CORONARY ARTERY DISEASE , AWSTEMI

SEVERE LV DYSFUNCTION,

PULMONARY EDEMA

CARDIOGENIC SHOCK

KILLIP CLASS-IV

HEART FAILURE

FC-IV

SINUS RHYTHM

CORONARY ANGIOGRAM DONE ON 21/06/2022 - CAD-LM+TVD

PLAN CABG.

C/o sudden onset chest pain since 1 day

At Admission

Afebrile

PR: 96/min

BP: 100/50 mmHg



RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-100%

A 60 years old female patient Mrs. VIJAYA LAXMI came with c/o sudden onset chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , AWSTEMI, SEVERE LV DYSFUNCTION, PULMONARY EDEMA, CARDIOGENIC SHOCK, CORONARY ANGIOGRAM DONE ON 21/06/2022 - CAD-LM+TVD, CTVS consultation taken and adviced CABG surgery. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

1. TAB. ATORVA 40 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. LASIX 20 MG THRICE DAILY AT 8AM 2PM AND 8PM TO CONTINUE.
3. TAB. ALDACTONE 25 MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

REVIEW AFTER 7 DAYS IN CARDIAC OPD

ARH1.0001232353

**Name**

Mr. SYED  
MOIN  
UDDIN

**Patient Identifier**

ARHIP56253

**Age** 51Yr 0Mth  
3Days

**Sex**

Male

**Date of Admission** 20-Jun-  
2022

**Date of Discharge**  
**MLC No**

**Address**

3-3-130,  
JAGITYAL,Karimnagar,Telangana

**Ward/  
Bed No** First  
Floor,  
CICU ,  
Bed  
no:CICU1  
0

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE IWMI

NORMAL LV SYSTOLIC FUNCTION, EF-60%

CORONARY ANGIOGRAM DONE ON 20/06/2022 - CAD-DVD (RCA, LCX)

PTCA+DES TO RCA WITH 3.0 X 13 MM METAFOR, LCX WITH 2.75 X 29 MM DONE ON  
20/06/2022

R/F: HTN, T2DM

C/o SOB on exertion, chest pain since 5 days

AT ADMISSION:

Afebrile

PR: 102/min

BP: 100/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 94%

P/A: Soft

A 51 years old male patient Mr. SYED MOIN UDDIN came with c/o SOB on exertion, chest pain since 5 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, NORMAL LV SYSTOLIC FUNCTION, EF-60% ,CORONARY ANGIOGRAM DONE ON 20/06/2022 - CAD-DVD (RCA, LCX), PTCA+DES TO RCA WITH 3.0 X 13 MM METAFOR, LCX WITH 2.75 X 29 MM DONE ON 20/06/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. NOVASTAT 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 4) TAB. BETALOC 150 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 5) TAB. GLYCOMET SR 850 MG ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001232361

		<b>Name</b>	Mr. MARRI SLEEVA REDDY	
<b>Patient Identifier</b>	ARHIP56263	<b>Age</b>	71Yr 0Mth 2Days	
<b>Sex</b>	Male	<b>Date of Admission</b>	21-Jun- 2022	
<b>Date of Discharge</b>				
<b>MLC No</b>				
<b>Address</b>	8-7-179/1, KOTHIRAMPUR,,Karimnagar,Telangana		<b>Ward/ Bed No</b>	First Floor, CICU , Bed no:CICU1 1
<b>Primary Consultant</b>	Dr. KRISHNA CHAITANYA M			

CAG: MILD CORONARY ARTERY DISEASE

CALCIFIC

SEVERE AORTIC STENOSIS

MODERATE LV DYSFUNCTION

GLOBAL LV HYPOKINESIA

CONTRACTED HF

SINUS RHYTHM

Complaints of worsening dyspnea NYHA, FC-II to FC-IV over last couple of weeks

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 91/min

BP: 100/70mmHg

RS: B/l basal crepts+

CVS: S1S2

RR: 20/min

SPO2: 95%

P/A: Soft

Mr. MARRI SLEEVA REDDY 71 year old male patient presented with complaints of worsening dyspnea NYHA, FC-II to FC-IV over last couple of weeks. On evaluation, he was and heart failure and pulmonary edema with bilateral crepitations. With IV diuretics and heart failure medication, he improved symptomatically. Once stabilized, coronary angiogram was done. CAG showed mid LAD 50% stenosis (moderate CAD) . He required medical management only for coronary artery disease. With severe calcific aortic stenosis, with onset of dyspnoea and a heart failure, poor prognosis explained to family members. Explained the option of aortic valve replacement and TAVR. In view of LV dysfunction, AVR is relatively high risk for him. Options were discussed with family members. Patient is being discharged in hemodynamically stable with required medication and advise.

#### DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN AV 75/10 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. FRUSELAC DS 1 TAB AT 8AM AND ½ TAB AT 8 PM TO CONTINUE.
3. TAB. LASIX 40MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. PAN 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

## PatientDetails

<b>UHID</b>	ARH1.0001232362	<b>Name</b>	Mr. VPJ VENKATESH
<b>Patient Identifier</b>	ARHIP56291	<b>Age</b>	52Yr 0Mth 2Days
<b>Sex</b>	Male	<b>Date of Admission</b>	23-Jun-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	B9, CC TOWNSHIP,SCCL,,Mancheria,Telangana	<b>Ward/Bed No</b>	Ground Floor, Emergency Ward, Bed no:EME6
<b>Primary Consultant</b>	Dr. KRISHNA CHAITANYA		

MILD MID LAD

MYOCARDIAL BRIDGING

NO OBSTRUCTIVE CAD

Complaints of worsening dyspnea NYHA, FC-II to FC-IV over last couple of weeks

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 80/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 19/min

SPO2: 98%

P/A: Soft

Mr. VPJ. VENKATESH 52 year old male patient presented with complaint of angina on evaluation, his TMT test was stage-II positive for inducible ischaemia. Hence, coronary angiogram done showed mid LAD, mild myocardial bridging. He was started on beta-blocker and advised medical management. He was asymptomatic and stable at the time of discharge.

DISCHARGE MEDICATION:

-----

1. TAB. AZTOR 10 MG ONCE DAILY AT 8PM TO CONTINUE.
2. TAB. MET-XL 25 MG ONCE DAILY AT 8AM TO CONTINUE.
3. CONTINUE DIABETIC MEDICATION AS ADVISED BY PHYSICIAN

REVIEW AFTER 11 DAYS TO CARDIAC OPD



ARH1.0001232292

**Name**

Mr.  
MURALI  
CHINTHA

**Patient Identifier**

ARHIP56230

**Age**

45Yr  
0Mth  
6Days

**Sex**

Male

**Date of Admission**

18-Jun-2022

**Date of Discharge**  
**MLC No**

**Address**

H.NO:5-5-  
158,JAGITIAL,Other,Telangana

**Ward/  
Bed No**

First  
Floor,  
CICU ,  
Bed  
no:CICU  
3

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE AWM I

SEVERE LV DYSFUNCTION, EF-25%

CORONARY ANGIOGRAM DONE ON 21/06/2022 - CAD-SVD (LAD, D1)

PTCA+DES TO LAD, D1 (TWO STENTS) LAD WITH 3.5 X 19 MM METAFOR, D1 WITH 2.5 X 24 MM METAFOR DONE ON 21/06/2022

C/o chest pain since 1 month,

H/o SOB since 1 day

AT ADMISSION:

Afebrile

PR: 125/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 88%

P/A: Soft

A 45 years old male patient Mr. MURALI CHINTHA came with c/o chest pain since 1 month, h/o SOB since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, SEVERE LV DYSFUNCTION, EF-25%, CORONARY ANGIOGRAM DONE ON 21/06/2022 - CAD-SVD (LAD, D1), PTCA+DES TO LAD, D1 (TWO STENTS) LAD WITH 3.5 X 19 MM METAFOR, D1 WITH 2.5 X 24 MM METAFOR DONE ON 21/06/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 3) TAB. CARDIVAS 6.25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 4) TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. PRASUDOC 10 MG ONCE DAILY AT 2PM AFTER LUNCH TO CONTINUE.
- 6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

APH1.0001082707

		<b>Name</b>	Mr. BARLA BEERAAIAH	
<b>Patient Identifier</b>	ARHIP56276	<b>Age</b>	62Yr 10Mth 1Days	
<b>Sex</b>	Male	<b>Date of Admission</b>	21-Jun-2022	
<b>Date of Discharge</b>				
<b>MLC No</b>				
<b>Address</b>	VILLAGE CHILLAPALLY MANDAL MANTHANI,Karimnagar,Andhra Pradesh		<b>Ward/ Bed No</b>	First Floor, MICU, Bed no:MIC U 2
<b>Primary Consultant</b>	Dr Chandra Shekar Sathineni(MD (Internal			

## ACUTE FEBRILE ILLNESS WITH ACUTE CVA

c/o fever associated with giddiness and vomitings, generalized weakness

K/C/O HTN, DM

AT ADMISSION:

Afebrile

PR: 68/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 62 years old male patient Mr. BARLA BEERAIAH came with c/o fever associated with giddiness and vomitings, generalized weakness. All necessary investigations were done and diagnosed as ACUTE FEBRILE ILLNESS WITH ACUTE CVA. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75 MG ONCE DAILY AT 8PM TO CONTINUE.
- 3) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. STAMLO 5 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. STROCOT PLUS **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 6) TAB. SUPRA PLUS ONCE DAILY AT 8AM TO CONTINUE.
- 7) TAB. CALPOL 500 MG THRICE DAILY AT 8AM 2PM AND 8PM FOR 5 DAYS
- 8) TAB. PANTOCID 40MG ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001232219

**Name**

Mr. SANTHOSH  
BHEEMA

**Patient  
Identifier**

ARHIP56202

**Age**

25Yr  
0Mth  
8Days

**Sex**

Male

**Date of  
Admission**

16-Jun-  
2022

**Date of  
Discharge  
MLC No**

**Address**

MALLANNAPET,  
GOLLAPALLI,JAGITIAL,Karimnagar,Telanga  
na

**Ward/  
Bed No**

Secon  
d  
Floor,  
Semi  
Private  
, Bed  
no:119  
B

**Primary  
Consultant**

Dr. RAMCHANDER  
TORREM(DM(NEPHROLOGY

DELIBERATE SELF HARM  
PARAQUAT POISONING  
HEPATITIS  
MUCOSITIS

Came with history of consumption of unknown quantity of paraquat

AT ADMISSION:

Patient c/c

PR: 81/min

BP: 140/100mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft,

A 25 years old male patient Mr. SANTHOSH BHEEMA came with history of consumption of unknown quantity of paraquat . All necessary investigations were done and diagnosed as DELIBERATE SELF HARM, PARAQUAT POISONING, HEPATITIS, MUCOSITIS. Gastric lavage with 5 L of normal saline given. 250 gms of activated Charcoal. Haemoperfusion done 3 cycles, Patient stabilized. IV steroids and IV Cyclophosphomides were given. Patient showed some improvement. He is being discharged in a haemodynamically stable condition.

DISCHARGE MEDICATION:

-----

- 1) SYP. SUCRAL 1 tsp **THRICE IN A DAY AT 8 AM 2 PM 8 PM** FOR 5 DAYS
- 2) SYP. MUCAINE GEL 10 ml **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS
- 3) TAB. LONAZEP 0.5 MG ONCE DAILY AT 8PM FOR 5 DAYS
- 4) TAB. SERTA 25 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS
- 5) TAB. WYSOLONE 10MG ONCE DAILY AT 2PM FOR 5 DAYS
- 6) TAB. PANTOCID 40 MG ONCE DAILY AT 7AM BBF FOR 5 DAYS
- 7) TAB. SHELCAL 1 GM ONCE DAILY AT 2PM FOR 5 DAYS
- 8) TAB. UBILIFE ONCE DAILY AT 2PM FOR 5 DAYS
- 9) TAB. HEPAMERZ SACHETS ONCE DAILY AT 2PM FOR 5 DAYS

REVIEW AFTER 5 DAYS IN NEPHROLOGY OPD

ARH1.0001232351

**Name**

Mrs. RADHA  
PASARAKONDA

**Patient Identifier**

ARHIP56249

**Age**

59Yr  
5Mth  
23Days

**Sex**

Female

**Date of Admission**

20-Jun-2022

**Date of Discharge**  
**MLC No**

**Address**

16-2-31, SHIVAJINAGAR,  
GODAVARIKHANI  
PEDDAPALLY, Karimnagar, Telangana

**Ward/Bed No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:106  
A

**Primary Consultant**

DR. SRI KARAN UDDESH --

RHEUMATOID ARTHRITIS FLARE,  
CERVICAL RADICULOPATHY  
TYPE II DIABETES MELLITUS

C/o Multiple joint pains

H/o Generalized weakness since 2 months  
Known case of diabetic mellitus on treatment  
Known case of rheumatoid arthritis not on treatment

AT ADMISSION:

PR: 80/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98% on room air

P/A: Soft,

A 59 years old female patient Mrs. RADHA PASARAKONDA came with above mentioned complaints, patient presented with the above-mentioned complaints patient was diagnosed to RHEUMATOID ARTHRITIS FLARE, CERVICAL RADICULOPATHY, TYPE II DIABETES MELLITUS and was started on INJ. NUERIT PLUS, INJ. PAN, TAB WYSOLONE, TAB. PREGABID and other supportive



treatment. Neurosurgeon consultation taken and advice followed. The patient is symptomatically better and is being discharged with following advice.

DISCHARGE MEDICATION:

-----

1. TAB. WYSOLONE 20 MG ONCE DAILY AT 2PM FOR 5 DAYS THEN  
TAB. WYSOLONE 10 MG ONCE DAILY AT 2PM FOR 5 DAYS THEN  
TAB. WYSOLONE 5 MG ONCE DAILY AT 2PM FOR 5 DAYS THEN STOP
2. TAB. METHOTREXATE 7.5 MG OD ON WEDNESDAY ONLY FOR 30 DAYS
3. TAB. FOLVITE 5 MG OD EXCEPT ON WEDNESDAY FOR 30 DAYS
4. TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS
5. TAB. VIDLA-M 50/500 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 30 DAYS
6. TAB. GABAPIN-NT ONCE DAILY AT 8PM FOR 30 DAYS
7. TAB. NEURIT-CD3 ONCE DAILY AT 2PM FOR 30 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001231324

<b>Name</b>	Mr. JEEVAN REDDY K
<b>Patient Identifier</b>	ARHIP56277
<b>Age</b>	32Yr 0Mth 30Days
<b>Sex</b>	Male
<b>Date of Admission</b>	21-Jun-2022
<b>Date of Discharge</b>	
<b>MLC No</b>	
<b>Address</b>	DHARMARAM, PEDDAPALLI, Karimnagar, Telangana
<b>Ward/ Bed No</b>	Second Floor, Semi Private, Bed no:123A
<b>Primary Consultant</b>	Dr. GOUTHAM ROY (MS)(General

MULTIPLE LIPOMATOSIS

SURGERY : MULTIPLE EXCISION OF LIPOMAS DONE ON 23/06/2022

C/o multiple lipomas

PHYSICAL EXAMINATION:

ON ADMISSION

-----

Pt c/c/c

afebrile

PR-80/min

BP-120/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 32 yr old male patient Mr. JEEVAN REDDY K came with c/o multiple lipomas . All necessary investigations done and diagnosed as MULTIPLE LIPOMATOSIS, SURGERY : MULTIPLE EXCISION OF LIPOMAS DONE ON 23/06/2022. Findings: Multiple lipomas involving bilateral UL & LL with Abd. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

#### DISCHARGE MEDICATION:

1. TAB: ROXSAFE 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. TAB: FAMOCID 40 MG **TWICE IN A DAY AT 8 AM 8 PM** 5 DAYS.
5. GLUTAVALT SACHETS ONCE DAILY AT 2PM FOR 15 DAYS.

REVIEW AFTER 10 DAYS IN GENERAL SURGERY OPD.

ARH1.0001232480

**Name**

Mr. CH  
VAIKUNTAM

**Patient  
Identifier**

ARHIP56301

**Age**

65Yr  
0Mth  
1Days

**Sex**

Male

**Date of  
Admission**

23-Jun-  
2022

**Date of  
Discharge  
MLC No**

**Address**

MANCHERIYAL,Adilabad(Adilabad),Telang  
ana

**Ward/  
Bed No**

First  
Floor,  
CICU ,  
Bed  
no:CICU  
5

**Primary  
Consultant**

Dr. KRISHNA CHAITANYA M --  
CARDIOLOGY

CORONARY ARTERY DISEASE-CSA

TMT STAGE-II POSITIVE

NO HF, FC-II AOE, SR

CAG: ECTATIC CORONARIES WITH MINOR CAD- SLOW FLOW

PLAN-MEDICAL MANAGEMENT

C/o angina on exertion since 4 months a/w chest pain

K/c/o T2DM

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 80/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

Mr. CH VAIKUNTAM 65 years old male patient presented with c/o angina on exertion since past 4 months, worsening from FC-II-III in last 2 months. TMT done was stage-II positive for inducible ischaemia. Coronary angiogram done showed Ectatic coronaries with slow flow and minor CAD. His medications were optimised and being discharged with the following advice

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN-AV 75/10 MG ONCE DAILY AT 8PM TO CONTINUE.
2. TAB. NIKORAN 5 MG **TWICE IN A DAY AT 8 AM AND 8 PM** TO CONTINUE.
3. TAB. NITROCONTIN 2.6 MG **TWICE IN A DAY AT 8 AM AND 2 PM** TO CONTINUE.
4. TAB. FLAVEDAN MR 35 MG **TWICE IN A DAY AT 8 AM, 2PM AND 8 PM** TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001080684

<b>Name</b>	Mr. VENKATARAM REDDY ADABOINA
<b>Patient Identifier</b>	ARHIP56283
<b>Sex</b>	Male
<b>Date of Discharge MLC No</b>	
<b>Address</b>	HUSNABAD,Karimnagar,Telangana
<b>Primary Consultant</b>	Dr. KRISHNA CHAITANYA M -- CARDIOLOGY

<b>Age</b>	58Yr 1Mth 18Days
<b>Date of Admission</b>	22-Jun-2022
<b>Ward/ Bed No</b>	First Floor, CICU , Bed no:CICU 8

CORONARY ARTERY DISEASE, ACUTE AWTMI  
SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%  
CAG+PTCA TO LAD 1 STENT DONE ON 22/06/2022

C/o chest pain, shortness of breath since 1 day

AT ADMISSION:

Afebrile

PR: 123/min

BP: 150/110 mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 96%

P/A: Soft

A 58 years old male patient Mr. VENKATARAM REDDY ADABOINA came with history of chest pain was evaluated and diagnosed to have AWSTEMI, primary PTCA to LAD with drug eluting stent with 4 x 24 mm stent. Good result TIMI-III flow. He was asymptomatic and haemodynamically stable at discharge.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. AXCER 90MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 2) TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. MET-XL 50MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. NIKORAN 5 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 6) TAB. NITROCONTIN 2.6 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 7) TAB. RAMISTAR 2.5 MG ONCE DAILY AT 2PM TO CONTINUE.
- 8) TAB. FRUSELAC-DS ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD [30/06/2022] WITH CBC, RP2, FLP REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.



ARH1.0001219067		<b>Name</b>	Mrs. SHAIK AMEENA BEGAM
<b>Patient Identifier</b>	ARHIP56233	<b>Age</b>	47Yr 0Mth 17Days
<b>Sex</b>	Female	<b>Date of Admission</b>	19-Jun-2022
<b>Date of Discharge MLC No</b>			
<b>Address</b>	4-3-6, METPALLY JAGTIAL 6300746239,Telangana	<b>Ward/ Bed No</b>	Second Floor, Female General Ward, Bed no:GW 1
<b>Primary Consultant</b>	Dr. RAMCHANDER TORREM(DM(NEPHROLOGY) (NIMS),RENAL TRANSPLANT PHYSICIAN)-- NEPHROLOGY		

S

## CHRONIC KIDNEY DISEASE

C/o Shortness of breath, b/l pedal edema

AT ADMISSION:

PR: 124/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

A 47 years old female patient Mrs. SHAIK AMEENA BEGAM came with c/o shortness of breath, b/l pedal edema. All necessary investigations were done and diagnosed as CHRONIC KIDNEY DISEASE. Managed conservatively. 4 sessions of hemodialysis were done. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. SOBINIX DS ONCE DAILY AT 8AM AND 8PM TO CONTINUE.
2. TAB. CLOCEF-CV **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. KETOCHECK THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS
4. TAB. UBILIFE ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. MULTI-8 ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 5 DAYS IN NEPHROLOGY OPD

ARH1.0001231339

**Name**

Mr. T GOPI

**Patient Identifier**

ARHIP56320

**Age**

32Yr  
0Mth  
30Days

**Sex**

Male

**Date of Admission**

24-Jun-2022

**Date of Discharge  
MLC No**

**Address**

Metpalli,Karimnagar,Telangana

**Ward/  
Bed No**

First  
Floor,  
Day  
Care,  
Bed  
no:DC  
4

**Primary Consultant**

Dr. SURESH GOUD S(MS,M.Ch Urology

LEFT DJ STENT  
SURGERY: LEFT DJ STENT REMOVAL DONE ON 24.06.2022

Patient came for left DJ stent removal

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

All required investigations done and enclosed

A 32 yrs old male patient Mr. GOPI came for left DJ stent removal. SURGERY: LEFT DJ STENT REMOVAL DONE ON 24.06.2022. Post operative period was uneventful. Patient discharged in haemodynamically stable condition proper medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB: CIFRAN 500 MG TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
2. TAB: DROLGON TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
3. TAB: PAN 40MG ONCE DAILY AT 7AM BBF FOR 5DAYS.
4. TAB: A TO Z GOLD ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO UROLOGY OPD

56226

.0001232074

<b>Name</b>	Mr. DAYYALA KANKAIAH		
<b>Patient Identifier</b>	ARHIP56226	<b>Age</b>	60Yr 10Mth 11Days
<b>Sex</b>	Male	<b>Date of Admission</b>	18-Jun-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	2-10-596, JYOTHI NAGAR, Karimnagar, Telangana	<b>Ward/ Bed No</b>	Second Floor, Male General Ward, Bed no: GW 23
<b>Primary Consultant</b>	Dr. SURESH GOUD S(MS,M.Ch Urology(SVIMS), Consultant Urologist)--UROLOGY		

PROSTATOMEGALY  
SURGERY: TURP DONE ON 20/06/2022

C/o difficulty in passing urine since 1 week

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

All required investigations done and enclosed

A 60 yrs old male patient Mr. DAYYALA KANKAIAH came to the hospital with c/o difficulty in passing urine since 1 week. All necessary investigations done and diagnosed as PROSTATOMEGALY , SURGERY: TURP DONE ON 20/06/2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB: CIFRAN 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: PAN 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: A TO Z ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO UROLOGY OPD

56223

ARH1.0001232113

		Mrs. SRAVANTHI K	
<b>Patient Identifier</b>	ARHIP56223	<b>Age</b>	32Yr 0Mth 10Days
<b>Sex</b>	Female	<b>Date of Admission</b>	18-Jun-2022
<b>Date of Discharge MLC No</b>			
<b>Address</b>	PANNUR,Ramagundam,Telangana	<b>Ward/ Bed No</b>	Second Floor, Female General Ward, Bed no:GW 9
<b>Primary Consultant</b>	Dr. SURESH GOUD S(MS,M.Ch		

RIGHT RENAL CALCULUS  
RIGHT PCNL+DJ STENTING DONE ON 20.06.2022

C/o Right loin pain, burning micturition since 10 days

#### AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

All required investigations done and enclosed

A 32 yrs old female patient Mrs. SRAVANTHI came to the hospital with c/o right loin pain, burning micturition since 10 days. All necessary investigations done and diagnosed as RIGHT RENAL CALCULUS, SURGERY: RIGHT PCNL+DJ STENTING DONE ON 20.06.2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice. Patient explained for stent removal after 3 weeks.

#### DISCHARGE MEDICATION:

-----

1. TAB: CIFRAN 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: PAN 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: A TO Z ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO UROLOGY OPD, STENT REMOVAL AFTER 3 WEEKS

ARH1.0001232450	<b>Name</b>	Mrs. B SRILATHA	
<b>Patient Identifier</b>	ARHIP56318	<b>Age</b>	48Yr 0Mth 2Days
<b>Sex</b>	Female	<b>Date of Admission</b>	24-Jun-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	STHAMMAPLLI BOINPALLY,Sircilla,Telangana	<b>Ward/Bed No</b>	First Floor, Day Care, Bed no:DC 6
<b>Primary Consultant</b>	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)--	<b>Consultants</b>	



GENERAL SURGERY

**Surgeons** Dr. GOUTHAM ROY  
(MS(General  
Surgery),Consultant  
General Surgeon)--  
GENERAL SURGERY

**Anesthesiologists** Dr Subba Reddy  
Kuppannagari--  
ANAESTHESIOLOGY

☐ Diagnosi  
s

**Diagnosis**

[Add  
Diagnosis](#)

ARHIP56318 ARH1.000123245

☐ Surgery / Procedures  
Done

**Surgery / Procedure**

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
STAPLER HAEMORRHOIDECTOMY				

GRADE-IV INTERNAL HEMORRHOIDS  
SURGERY: STAPLER HEMORRHOIDECTOMY DONE ON 24/06/2022

C/o pain and bleeding per rectum since 10 days

PHYSICAL EXAMINATION:

ON ADMISSION

-----  
Pt c/c/c

afebrile

PR-80/min

BP-130/70mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

SPO2-100%

A 48 yrs old female patient SRILATHA came with c/o pain and bleeding per rectum since 10 days. All necessary investigations done and diagnosed as GRADE-IV INTERNAL HEMORRHOIDS, SURGERY: STAPLER HEMORRHOIDECTOMY DONE ON 24/06/2022. Findings: Multiple internal hemorrhoids noted @ 3'O & 7'O clock in position. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

#### Discharge Medication:

1. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. SYP. LACTIHEP 3 TSP ONCE IN A DAY AT 8 PM
4. XYLOCAINE JELLY EVERY 4<sup>th</sup> hrly
5. SITZ BATH
6. METROGYL-P OINTMENT L/A THRICE DAILY AT 8AM 2PM 8PM
7. GLUTAVULT SACHETS ONCE DAILY AT 8AM WITH GLASS OF WATER FOR 15 DAYS.

Review after 7 days in General Surgery OPD.

ARH1.0001220341

<b>Name</b>	Mr. JAFFAR KHAN MD		
<b>Patient Identifier</b>	ARHIP56240	<b>Age</b>	65Yr 9Mth 30Days
<b>Sex</b>	Male	<b>Date of Admission</b>	20-Jun-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	LAXMI NAGAR, PEDDAPALLI,Karimnagar,Telangana	<b>Ward/ Bed No</b>	First Floor, CICU , Bed no:CICU 4
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, AWMi [RECURRENT INFARCTION]

DRUG NON COMPLIANCE

K/C/O CAD- ACUTE AWMi

CORONARY ANGIOGRAM (30/08/2021) -SHOWING SLOW FLOW IN ALL CORONARIES, LAD PROXIMAL MILD STENOSIS WITH A SMALL CORONARY ANEURYSM

BPH (TO RULE OUT PROSTATE CA)

UTI (Fever with Thrombocytopenia)

C/o retrosternal chest pain radiating to back associated with sweating since 1 day  
History of burning micturition since 15 days

Known case of hypertension,  
Right renal calculi operated at 26 years back

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 90/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 65 years old male patient JAFFAR KHAN came with c/o retrosternal chest pain radiating to back associated with sweating since 1 day, history of burning micturition since 15 days. All necessary investigations were done and diagnosed as

I) CORONARY ARTERY DISEASE, AWTMI [RECURRENT INFARCTION], DRUG NON COMPLIANCE, K/C/O CAD- ACUTE AWTMI, CORONARY ANGIOGRAM (30/08/2021) -SHOWING SLOW FLOW IN ALL CORONARIES, LAD PROXIMAL MILD STENOSIS WITH A SMALL CORONARY ANEURYSM + BPH (TO RULE OUT PROSTATE CA) + A UTI + THROMBOCYTOPENIA. Patient was deferred coronary angiogram due to reasons of

1. Thrombocytopenia
2. UTI with fever and chills
3. Raised Sr. Creatinine
4. Resolution of ECG changes
5. subsiding of chest pain and breathlessness after giving antiplatelets and anticoagulants

II) BPH and UTI for which nephrology and Urology consultation was done and treated accordingly.

III) Thrombocytopenia for which General Physician Consultation was done and treated accordingly.

Patient is being planned discharged medical management and foley's catheter in situ in a haemodynamically stable condition.

Review to Urology OPD, Nephrology OPD and Cardiac OPD with RP-II and CBC reports after 1 week

#### DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. FAROBACT 200 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. SOBINEX DS 500MG ONCE DAILY AT 8AM TO CONTINUE.

6. TAB. RENOSAVE 40MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. KETOCHECK **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
8. TAB. URIMAX-D ONCE DAILY AT 8PM TO CONTINUE.
9. SYP. ALKAPAN 1tsp **THRICE IN A DAY AT 8 AM, 2PM & 8 PM** TO CONTINUE.
10. TAB. PAN 40MG ONCE DAILY AT 7AM BBF FOR 7 DAYS
11. TAB. DOLO 650 MG **TWICE IN A DAY AT 8 AM, 8 PM** FOR 7 DAYS.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001232258

**Name**

Mr.  
NAGARAJU  
REDDY

**Patient Identifier**

ARHIP56219

**Age**

0Yr  
0Mth  
8Days

**Sex**

Male

**Date of  
Admission**

18-Jun-  
2022

**Date of Discharge  
MLC No**

**Address**

KRISHANA COLONY RK  
6,Karimnagar,Telangana

**Ward/  
Bed No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:105  
B

**Primary Consultant**

DR. SUBRAT KUMAR SOREN

- 1.CEREBRAL VENOUS THROMBOSIS  
[ ANTERIOR TWO THIRD SUPERIOR SAGITTAL SINUS THROMBOSIS]
- 2.HAEMORRHAGIC INFARCT
- 3.SEIZURE DISORDER

Complaint of neck pain, giddiness, 1 episode of seizure (GTCS)  
History of retrosternal chest pain  
History of seizures in childhood (5 years of age)  
History of chronic alcoholic  
Known case of hypertension

AT ADMISSION:

Patient c/c/c

PR: 69/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 97%

P/A: Soft

A 29 yr old male patient NAGARAJU REDDY came to hospital with complaint of neck pain, giddiness, 1 episode of seizure (GTCS). All necessary investigations done and diagnosed as 1.CEREBRAL VENOUS THROMBOSIS [ ANTERIOR TWO THIRD SUPERIOR SAGITTAL SINUS THROMBOSIS], 2.HAEMORRHAGIC INFARCT, 3.SEIZURE DISORDER. Conservative medical management given. Patient is being discharged in a hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ACITROM 2 MG ONCE DAILY AT 6 PM TO CONTINUE
2. TAB. LEVIPIL 500 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE
3. TAB. CLOBAZAM 10 MG ONCE DAILY AT 8 PM TO CONTINUE
4. TAB. TELMA-H ONCE DAILY AT 8 AM TO CONTINUE
5. TAB. LIBRIUM 20 MG ONCE DAILY AT 8 PM TO CONTINUE
6. TAB: PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 10 DAYS.
7. TAB: AUGMENTIN DUO 625 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
8. TAB. DOLO 650 TWICE DAILY AT 8AM, 8PM FOR 5DAYS.
9. TAB. BENFOMATE PLUS ONCE **IN A DAY AT 2 PM** FOR 10 DAYS.

REVIEW AFTER 7 DAYS IN NEUROSURGERY OPD WITH PT, APTT+INR.



ARH1.0001231870

<b>Name</b>	Mrs. AMULA KASHAVVA
<b>Patient Identifier</b>	ARHIP56153
<b>Sex</b>	Female
<b>Date of Discharge</b>	
<b>MLC No</b>	
<b>Address</b>	MITTAPALLI SIDDIPET MEDAK, Siddipet, Telangana
<b>Primary Consultant</b>	Dr SOMASHEKAR K(MS,M
<b>Age</b>	
<b>Date of Admission</b>	
<b>Ward/Bed No</b>	

CRHD WITH SEVERE MS + MODERATE AS

SURGERY: DVR, MVR WITH TTKC NO. 27 MM, AVR WITH TTKC NO. 17 MM  
MECHANICAL VALVE DONE ON 20/06/2022

C/o SOB on exertion a/w palpitations since 3 days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 61 years old female patient Mrs. AMULA KASHAVVA came with c/o SOB on exertion a/w palpitations since 3 days. All necessary investigations were done and diagnosed as CRHD WITH SEVERE MS + MODERATE AS, SURGERY: DVR, MVR WITH TTKC NO. 27 MM, AVR WITH TTKC NO. 17 MM MECHANICAL VALVE DONE ON 20/06/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, she is being discharged with required medication and advice.

POST DVR 2D ECHO REPORTS SHOWED POST DVR STATUS , PROSTHETIC VALVE INSITU, NO VALVULAR/ PARAVALVULAR LEAK, NORMAL LV FUNCTION. NO CLOT/PE/VEG, [EF-50%]

BMI is 21 kg/m<sup>2</sup>.

Sr. Creatinine report done on 21.06.2022 0.9 mg/dl

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ACITROM 1 MG & 2MG ALTERNATE DAY AT 7PM TO CONTINUE.
- 2) TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.
- 4) TAB. ND VIT ONCE DAILY AT 2 PM TO CONTINUE
- 5) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.
- 6) TAB. TRAMADOL 50MG THRICE DAILY AT 8AM, 2PM AND 8PM FOR 5 DAYS.
- 7) TAB. ALPRAX 0.25 MG ONCE DAILY AT 8PM FOR 5 DAYS.
- 8) SYP. CREMAFFIN 2tsp THRICE DAILY AT 8AM, 2PM AND 8PM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD WITH PT-INR REPORTS

ARH1.0001232491

Name

Mrs.  
DEVENDRA A

Patient  
Identifier

ARHIP56316

Age

50Yr  
0Mth  
1Days

Sex

Female

Date of  
Admission

24-Jun-  
2022

Date of  
Discharge  
MLC No

25-Jun-2022

Address

ALUGUNUR,Karimnagar,Telangana

Ward/Bed No

First  
Floor,  
MICU,  
Bed  
no:MIC  
U 7

Primary  
Consultant

DR. SANJAY KUMAR  
KAMINWAR(MD,DM(Neurology),Consult  
ant Neuro Physician)--NEUROLOGY

Consultants

Surgeons

Anesthesiologi  
sts

Diagnosis

Diagnosis

Disease	Disease Type
BENZODIAZEPINE OVERDOSE	

Patient brought to Emergency Room in unconscious state

Known case of hypertension on irregular medication

AT ADMISSION:

Afebrile

PR: 96/min

BP: 150/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 50 years old female patient Mrs. DEVENDRA came with patient brought to Emergency Room in unconscious state. Known case of hypertension on irregular medication. All necessary investigations were done and diagnosed as BENZODIAZEPINE OVERDOSE. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. SERTA 25 MG ONCE DAILY AT 2PM FOR 5 DAYS
2. TAB. LONAZEP 0.5 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
3. TAB. FLEXURA-D TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
4. TAB. PANTOCID DSR ONCE DAILY AT 7AM (BBF) FOR 5 DAYS.

REVIEW AFTER 5 DAYS IN DR. SANJAY KUMAR SIR OPD

ARH1.0001231273

		<b>Name</b>	Mrs. U KANAKAMMA	
<b>Patient Identifier</b>	ARHIP56289	<b>Age</b>	73Yr 1Mth 1Days	
<b>Sex</b>	Female	<b>Date of Admission</b>	22-Jun-2022	
<b>Date of Discharge</b>				
<b>MLC No</b>				
<b>Address</b>	KARIMNAGAR,Karimnagar,Telangana		<b>Ward/Bed No</b>	Second Floor, Delux Room, Bed no:104
<b>Primary Consultant</b>	DR. SRI KARAN UDDESH --INTERNAL MEDICINE			

## GLIOBLASTOMA MULTIFORME

Patient has decreased response since 2 days  
shortness of breath grade -III since 2-3 days

Known case of glioblastoma multiforme

### AT ADMISSION:

Afebrile

PR: 83/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 100% on room air

P/A: Soft,

A 73 years old female patient KANAKAMMA came with above mentioned complaints. Patient diagnosed as GLIOBLASTOMA MULTIFORME. Patient admitted only for palliative treatment with end of Life Care. All the aspects have been explained to the relatives. Her son Mr. Sudarshan signed a paper to that effect. Now they want the patient to be discharged against medical advice . GCS 6/15.

ARH1.0001232400

**Name**

Mr. V  
VINAY  
KUMAR

**Patient Identifier**

ARHIP56271

**Age**

31Yr  
0Mth  
4Days

**Sex**

Male

**Date of  
Admission**

21-Jun-  
2022

**Date of Discharge  
MLC No**

**Address**

kamanpur,peddapalli,Karimnagar,Telana  
gana

**Ward/  
Bed No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:122  
B

**Primary Consultant**

Dr Chandra Shekar Sathineni

ACUTE FEBRILE ILLNESS  
ACUTE VIRAL HEPATITIS (HEPATITIS - A)

Complaint of fever with chills since 7 days  
History of vomitings, blood in urine  
Yellowish discolouration of eye, generalised weakness

AT ADMISSION:

Afebrile

PR: 80/min

BP: 110/60 mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 31 years old male patient Mr. V VINAY KUMAR came with c/o fever with chills since 7 days, history of vomitings, blood in urine, Yellowish discolouration of eye, generalised weakness. All necessary investigations were done and diagnosed as ACUTE FEBRILE ILLNESS, ACUTE VIRAL HEPATITIS (HEPATITIS - A). Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

- 1) TAB. URSOCOL 300 MG TWICE DAILY AT 8AM AND 8PM FOR 30 DAYS
- 2) TAB. MEBGRAM 200 MG TWICE DAILY AT 8AM AND 8PM FOR 30 DAYS
- 3) TAB. RAZO-D ONCE DAILY AT 7AM (BBF) FOR 30 DAYS.
- 4) SYP. APTIVATE 5 ML TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD



ARH1.0001232442

<b>Name</b>	Mrs. BALAMANI CH
<b>Patient Identifier</b>	ARHIP56296
<b>Age</b>	48Yr 0Mth 2Days
<b>Sex</b>	Female
<b>Date of Admission</b>	23-Jun-2022
<b>Date of Discharge</b>	
<b>MLC No</b>	
<b>Address</b>	8 IN CLINE COLONY, RAMAGUNDAM, PEDDAPALLI, Karimnagar, Telangana
<b>Ward/ Bed No</b>	Second Floor, Semi Private, Bed no:108A
<b>Primary Consultant</b>	Dr. SURESH GOUD S(MS,

LEFT PYELONEPHRITIS  
SURGERY: LEFT DJ STENTING DONE ON 23.06.2022

C/o no urine output since 1 day

Left flank pain since 1 day

Known case of hypertension since 2 years  
History of right nephrectomy in 2004  
S/P right thalamic haematoma

ON ADMISSION

-----

Patient c/c

Afebrile

PR-81/min

BP-110/70mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft

SPO2-99%

A 48 years old female patient Mrs. BALAMANI presented to hospital with c/o no urine output since 1 day, left flank pain since 1 day. All necessary investigations were done and diagnosed as LEFT PYELONEPHRITIS, SURGERY: LEFT DJ STENTING DONE ON 23.06.2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB: ROXSAFE CV 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DROLGON TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: PAN-D 40MG ONCE DAILY AT 7AM BBF FOR 10 DAYS.
4. TAB: A TO Z GOLD ONCE DAILY AT 2PM FOR 10 DAYS
5. TAB. VELTAM 0.2 MG ONCE DAILY AT 8PM FOR 14 DAYS.
6. SYP. ALKAPAN 15 ml **THRICE IN A DAY AT 8 AM, 2PM & 8 PM** TO CONTINUE.

REVIEW AFTER 7 DAYS TO UROLOGY OPD.

REVIEW AFTER 3 WEEKS FOR DJ STENT REMOVAL.

ARH1.0001231781

		Mrs. PRAMEELA AREPALLI	
<b>Patient Identifier</b>	ARHIP56257	<b>Age</b>	41Yr 0Mth 19Days
<b>Sex</b>	Female	<b>Date of Admission</b>	20-Jun-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	8-9, VEDIRA,KARIMNAGAR,Karimnagar,Telangana	<b>Ward/Bed No</b>	Second Floor, Female General Ward, Bed no:GW 3
<b>Primary Consultant</b>	Dr. SURESH GOUD S(MS		

RIGHT RENAL CALCULUS  
SURGERY : RIGHT PCNL + DJ STENTING DONE ON 21.06.2022

C/o Right loin pain, burning micturition since 10 days

**AT ADMISSION:**

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

All required investigations done and enclosed

A 41 yrs old female patient PRAMEELA AREPALLI came to the hospital with c/o right loin pain, burning micturition since 10 days. All necessary investigations done and diagnosed as RIGHT RENAL CALCULUS, SURGERY : RIGHT PCNL + DJ STENTING DONE ON 21.06.2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice. Patient explained for stent removal after 3 weeks.

#### DISCHARGE MEDICATION:

-----

1. TAB: ROXSAFE CV 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: PAN 40MG ONCE DAILY AT 7AM BBF FOR 11DAYS.
4. TAB: A TO Z GOLD ONCE DAILY AT 2PM FOR 11 DAYS

REVIEW AFTER 11 DAYS TO UROLOGY OPD, STENT REMOVAL AFTER 3 WEEKS

ARH1.0001232298

		<b>Name</b>	Mrs. GOSKULA ILAVVA	
<b>Patient Identifier</b>	ARHIP56232	<b>Age</b>	76Yr 0Mth 6Days	
<b>Sex</b>	Female	<b>Date of Admission</b>	19-Jun-2022	
<b>Date of Discharge</b>				
<b>MLC No</b>				
<b>Address</b>	CHERLABUTHKUR,Karimnagar,Telangana		<b>Ward/Bed No</b>	Second Floor, Female General Ward, Bed no:GW 2
<b>Primary Consultant</b>	DR. SANJAY KUMAR KAMINWAR			

## ACUTE POSTERIOR CIRCULATION STROKE

Complaints of slurring of speech

Known case of hypertension

### AT ADMISSION:

Afebrile

PR: 76/min

BP: 100/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 97%

P/A: Soft,

A 76 years old female patient Mrs. GOSKULA ILAVVA came with complaints of slurring of speech. All necessary investigations done and diagnosed as ACUTE POSTERIOR CIRCULATION STROKE. Managed conservatively . Patient improved symptomatically, hence now patient is being discharged in a hemodynamically stable condition with all the required medications and advice.

DISCHARGE MEDICATION :

-----

- 1) TAB. PREVA-AS 75 MG ONCE DAILY AT 2PM FOR 10 DAYS
- 2) TAB. COLTRO 10 MG ONCE DAILY AT 8PM FOR 10 DAYS
- 3) TAB. DUZELLA 20 MG ONCE DAILY AT 2PM FOR 10 DAYS
- 4) TAB. SPINFREE ONCE DAILY AT 2PM FOR 5 DAYS

REVIEW AFTER 11 DAYS IN DR. SANJAY KUMAR SIR OPD

ARH1.0001232352

**Name**

Mrs.  
VENNAM  
MALLAVVA

**Patient Identifier**

ARHIP56252

**Age**

66Yr  
5Mth  
5Days

**Sex**

Female

**Date of  
Admission**

20-Jun-  
2022

**Date of Discharge  
MLC No**

**Address**

9-5-193,  
RAMNAGAR,Karimnagar,Telang  
ana

**Ward/  
Bed No**

Second  
Floor,  
Female  
Genera  
l Ward,  
Bed  
no:GW  
11

**Primary Consultant**

DR. NIKHIL GOLI --NEUROLOGY

ACUTE INFARCTS IN POSTERIOR CIRCULATION

Complaint of giddiness and vomitings multiple episodes since 2 days

Known case of hypertension on regular medication

AT ADMISSION:

Afebrile

PR: 75/min

BP: 130/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 95%

P/A: Soft,

A 66 years old female patient Mrs. VENNAM MALLAVVA came with complaints of giddiness and vomitings multiple episodes since 2 days. All necessary investigations done and diagnosed as ACUTE INFARCTS IN POSTERIOR CIRCULATION. Managed conservatively . Patient improved symptomatically, hence now patient is being discharged in a hemodynamically stable condition with all the required medications and advice.

DISCHARGE MEDICATION :

-----

1) TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM FOR 10 DAYS

2) TAB. ATORVA 40 MG ONCE DAILY AT 2PM FOR 10 DAYS

3) TAB. SUPRADYN ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 11 DAYS IN DR. NIKHIL GOLI SIR OPD



ARH1.0001232405

**Name**

Mr. S D MOULANA

**Patient Identifier**

ARHIP56278

**Age**

71Yr  
0Mth  
4Days

**Sex**

Male

**Date of Admission**

21-Jun-2022

**Date of Discharge  
MLC No**

**Address**

NEW  
MOGALIPALEM,Karimnagar,Telangana

**Ward/  
Bed No**

Second  
Floor,  
Male  
General Ward,  
Bed  
no:GW  
21

**Primary Consultant**

Dr. KRISHNA CHAITANYA

CAD, IWSTEMI  
CAG: RCA TOTAL THROMBOTIC OCCLUSION  
LAD MID 60% STENOSIS  
FAIR LV FUNCTION, LVEF 50%  
SINUS RHYTHM

Complaint of chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

Mr. MOULANA , 71-year-old gentleman came with complaint of chest pain since 1 day. On evaluation showed STEMI. He was taken up for primary angioplasty, PTCA to RCA done and LAD vessel had borderline 60% stenosis. He was stabilised and medication was optimised. He was symptomatically better and haemodynamically stable at discharge.

#### DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.
5. TAB. NIKORAN 5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. FLAVEDAN MR 35MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. NITROCONTIN 2.6MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
8. TAB. MET-XL 25 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 1 WEEK TO CARDIAC OPD WITH CBC, RP-2 TO REPORTS

ARH1.0001098189

**Name**

Mrs. MANCHALA  
VASANTHA

**Patient  
Identifier**

ARHIP56259

**Age**

40Yr  
4Mth  
29Days

**Sex**

Female

**Date of  
Admission**

21-Jun-  
2022

**Date of  
Discharge  
MLC No**

**Address**

MODELA,Adilabad(Adilabad),Telangana

**Ward/  
Bed No**

Second  
Floor,  
Male  
General Ward,  
Bed  
no:GW  
22

**Primary  
Consultant**

Dr. KRISHNA CHAITANYA

CAD, OLD AWMI, S/P PTCA TO LAD  
NOW, UNSTABLE ANGINA  
NOW H F,  
LVEF 35%-40%,  
SINUS RHYTHM  
CAG: RCA MID 80% STENOSIS  
PTCA TO RCA (3.5 X 16 MM METAPHOR) DONE ON 22/06/2022

Complaint of chest discomfort since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

Mrs. MANCHALA VASANTHA 40-year-old female presented with chest discomfort, unstable angina. Evaluated and CAG done showed mid RCA 80% stenosis. Hence PTCA to RCA with 3.5 x 15 mm Metahor stent. TIMI, III flow. Good result. Her medications were optimized. She was stable and symptomatically better at the time of discharge.

#### DISCHARGE MEDICATION:

- 
1. TAB. CLOPIDOGREL 75 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
  2. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
  3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
  4. TAB. PANTODAC 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS.
  5. TAB. FLAVEDAN MR 35MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
  6. TAB. MET-XL 25 MG ONCE DAILY AT 8AM TO CONTINUE.
  7. TAB. IVABRADINE 5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
  8. CONTINUE DIABETIC MEDICATION AS ADVISED BY PHYSICIAN

REVIEW AFTER 1 WEEK TO CARDIAC OPD WITH CBC, RP-2 TO REPORTS

ARH1.000113233  
2

Name

Mrs. A  
RATNAMMA

Patient  
Identifier ARHIP56285

Age 73Yr 0Mth 19Days

Sex Female

Date of  
Admission 22-Jun-2022

Date of  
Discharge

**MLC No**

**Address** SIRCILLA,Karimnagar,Telanga  
na

**Ward/Bed No** First Floor,  
RECOVERY ROOM,  
Bed no:RR 1

**Primary Consultant** Dr. GOUTHAM ROY  
(MS(General  
Surgery),Consultant General  
Surgeon)--GENERAL  
SURGERY

**Consultants**

**Surgeons** Dr. GOUTHAM ROY  
(MS(General  
Surgery),Consultant General  
Surgeon)--GENERAL  
SURGERY

**Anesthesiologists** Dr Subba Reddy  
Kuppannagari--  
ANAESTHESIOLOGY

☐ **Diagnosis**

**Diagnosis**

[Add  
Diagnosis](#)

ARHIP56285	ARH1.000113233
------------	----------------

☐ **Surgery / Procedures  
Done**

**Surgery / Procedure**

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
OPEN VENTRAL HERNIA REPAIR WITH MESH REPAIR ONLEY				

S

VENTRAL HERNIA INVOLVING RIGHT ABDOMINAL WALL

SURGERY: OPEN VENTRAL HERNIA REPAIR (ONLY MESH REPAIR) DONE ON 24/06/22

C/o swelling over right abdomen region since few days

PHYSICAL EXAMINATION:

ON ADMISSION

-----

Pt c/c/c

afebrile

PR-81/min

BP-120/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 73yr old female patient Mrs. A. RATNAMMA came with c/o swelling over right abdomen region since few days. All necessary investigations done and diagnosed as VENTRAL HERNIA INVOLVING RIGHT ABDOMINAL WALL, SURGERY: OPEN VENTRAL HERNIA REPAIR (ONLY MESH REPAIR) DONE ON 24/06/22. Findings: Defect involving right lower abdomen measuring 3 x 2 cm with omentum as its contents. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. TAB: ROTAVAUULT THRICE DAILY AT 8AM, 2PM & 8PM FOR 7 DAYS
5. GLUTAVAUULT SACHETS ONCE DAILY AT 2PM FOR 15 DAYS.

REVIEW AFTER 7 DAYS IN GENERAL SURGERY OPD.

56270

Chest pain associated with vomiting Since 1 day

Known case of hypertension

AT ADMISSION:

Afebrile

PR: 90/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

Mr. Mr. MOHAMMED IBRAHIM 43-year-old male presented with chest pain associated with vomiting since 1 day.

CAG was done -Normal coronaries. His medication optimised . He was asymptomatic and haemodynamically stable at the time of discharge



DISCHARGE MEDICATION:

-----

1. TAB. ATORVA 10MG ONCE DAILY AT 8PM TO CONTINUE.
2. TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS.
3. TAB. ANKIT 0.2 MG ONCE DAILY AT 8PM TO CONTINUE.

REVIEW AFTER 1 WEEK TO CARDIAC OPD

ARH1.0001232391

<b>Name</b>	Mrs. KALAVATHI BANDARI
<b>Patient Identifier</b>	ARHIP56266
<b>Age</b>	67Yr 5Mth 8Days
<b>Sex</b>	Female
<b>Date of Discharge</b>	21-Jun-2022
<b>MLC No</b>	
<b>Address</b>	6-8-82, SUBHASH NAGAR, Karimnagar, Telangana
<b>Ward/ Bed No</b>	First Floor, MICU, Bed no: MICU 9
<b>Primary Consultant</b>	Dr. RAMCHANDER TORRENT

CHRONIC KIDNEY DISEASE, STAGE-V  
HYPERTENSION  
BRONCHIAL ASTHMA

C/o shortness of breath, decreased urine output and bilateral pedal oedema  
Known case of hypertension, bronchial asthma

AT ADMISSION:

Afebrile

PR: 75/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 97%

P/A: Soft

A 67 years old female patient Mrs. KALAVATHI BANDARI came with c/o shortness of breath, decreased urine output and bilateral pedal oedema, Known case of hypertension, bronchial asthma. All necessary investigations were done and diagnosed as CHRONIC KIDNEY DISEASE, STAGE-V, HYPERTENSION, BRONCHIAL ASTHMA. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

#### DISCHARGE MEDICATION:

-----

1. TAB. FAROALFA 200MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
2. TAB. MOUNTAIR-AB **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. FAROALFA 200MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. CALCI-CZ ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. MUCINAC THRICE IN A DAY AT 8 AM 2 PM 8 PM TO CONTINUE.
6. TAB. MONTAIR-AB **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. SYP. ASCORYL-LS 5 ml THRICE IN A DAY AT 8 AM 2 PM 8 PM
8. NEB WITH DUOLIN, BUDERCORT **TWICE IN A DAY AT 8 AM 8 PM**
9. TAB. DYTOR 20MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
10. TAB. NICARDIA R 20MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

REVIEW AFTER 7 DAYS TO NEPHROLOGY OPD

ARH1.0001232565

**Name**

Mrs. D  
KALAVATHI

**Patient  
Identifier**

ARHIP56336

**Age**

62Yr  
0Mth  
4Days

**Sex**

Female

**Date of  
Admission**

25-Jun-  
2022

**Date of  
Discharge  
MLC No**

**Address**

BELLAMPALLI,Telangana

**Ward/  
Bed No**

First  
Floor,  
MICU,  
Bed  
no:MIC  
U 7

**Primary  
Consultant**

DR. SANJAY KUMAR  
KAMINWAR(MD,DM(Neurology),Consult  
ant Neuro Physician)--NEUROLOGY

CVA-ACUTE LEFT MCA INFARCT  
THROMBOLISATION WITH TENECTASE ON 25/06/22

C/o right upper limb and lower limb weakness. H/o slurring of speech

ON ADMISSION

-----

Pt c/c

Afebrile

PR-80/min

BP-130/70mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft, BS+

SPO2-98%

A 62 years old female patient Mrs. KALAVATHI presented to hospital with c/o right upper limb and lower limb weakness. H/o slurring of speech. All necessary investigations were done and diagnosed as CVA- ACUTE LEFT MCA INFARCT, THROMBOLISATION WITH TENECTASE ON 25/06/22. Patient was treated conservatively and improved symptomatically. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

- 1) TAB. PREVA AS 75MG 1TAB AT 2PM TO CONTINUE.
- 2) TAB. AZTOR 40MG 1TAB AT 9PM TO CONTINUE.
- 3) TAB. TELMA 40MG 1TAB AT 8AM TO CONTINUE.
- 4) TAB. ZORYL-M2 1TAB **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

REVIEW AFTER 10 DAYS TO DR. SANJAY KUMAR KAMINWAR OPD WITH FBS, PLBS REPORTS.

ARH1.0001232476

**Name**

Mr.  
MUBEEN  
MOHAMMA  
D

**Patient  
Identifier**

ARHIP56303

**Age**

50Yr  
4Mth  
6Days

**Sex**

Male

**Date of  
Admission**

23-Jun-  
2022

**Date of  
Discharge  
MLC No**

**Address**

5-3-18, HAZARI  
STREET,JAGTIAL,Karimnagar,Telanga  
na

**Ward/  
Bed No**

Second  
Floor,  
Male  
General Ward,  
Bed  
no:GW  
18

**Primary  
Consultant**

DR. SANJAY KUMAR KAMINWAR

CVA-ACUTE RIGHT MCA INFARCT

C/o sudden onset weakness of left upper limb and lower limb.

Known case of hypertension, diabetic mellitus, old CVA

ON ADMISSION

-----

Pt c/c/c

Afebrile

PR-96/min

BP-140/90mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft, BS+

SPO2-98%

A 50 years old male patient Mr. MUBEEN MOHAMMAD presented to hospital with c/o sudden onset weakness of left upper limb and lower limb . All necessary investigations were done and diagnosed as CVA-ACUTE RIGHT MCA INFARCT. Patient was treated conservatively and improved symptomatically. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

- 1) TAB. PREVA AS 75MG 1TAB AT 2PM TO CONTINUE.
- 2) TAB. ATORVA 40MG 1TAB AT 9PM TO CONTINUE.
- 3) TAB. TELMA-H 1TAB AT 2PM TO CONTINUE.
- 4) TAB. GABAPIN NT 400/10 MG 1TAB AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO DR. SANJAY KUMAR KAMINWAR OPD.

ARH1.0001232474

**Name**

Mr.  
THIRUPATHI  
PAIDI

**Patient Identifier** ARHIP56299

**Age** 74Yr  
0Mth  
6Days

**Sex** Male

**Date of Admission** 23-Jun-2022

**Date of Discharge**  
**MLC No**

**Address** Other,Other

**Ward/ Bed No** Second  
Floor,  
Male  
General Ward,  
Bed  
no:GW  
15

**Primary Consultant** DR. SANJAY KUMAR  
KAMINWAR(

CVA-ACUTE RIGHT MCA INFARCT

C/o sudden onset weakness of left upper limb and lower limb.

Known case of hypertension, diabetic mellitus,

ON ADMISSION

-----

Pt c/c/c

Afebrile

PR-82/min

BP-110/70mmhg

RR-20/min

RS-BAE+,

CVS-S1S2+

P/A-Soft



SPO2-99%

A 74 years old male patient Mr. THIRUPATHI PAIDI presented to hospital with c/o sudden onset weakness of left upper limb and lower limb . All necessary investigations were done and diagnosed as CVA-ACUTE RIGHT MCA INFARCT. Patient was treated conservatively and improved symptomatically. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

- 1) TAB. PREVA AS 75MG 1TAB AT 2PM TO CONTINUE.
- 2) TAB. ATORVA 40MG 1TAB AT 9PM TO CONTINUE.
- 3) TAB. TELMIKIND 1TAB AT 2PM TO CONTINUE.
- 4) TAB. GLYCOMET 500 MG 1TAB AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO DR. SANJAY KUMAR KAMINWAR OPD.

ARH1.0001232472

**Name**

Mr.  
MARUTHA  
RAJAMOULI

**Patient Identifier**

ARHIP56323

**Age**

57Yr  
0Mth  
6Days

**Sex**

Male

**Date of Admission**

24-Jun-2022

**Date of Discharge**

**MLC No**

**Address**

LUXETTIPET ,Telangana

**Ward/Bed No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:123  
C

**Primary Consultant**

Dr Chandra Shekar Sathineni(MD  
(Internal Medicine) )--INTERNAL  
MEDICINE

**Consultants**

**Surgeons**

UNCONTROLLED DIABETES MELLITUS

c/o fever associated with Submandibular swelling

AT ADMISSION:

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 57 years old male patient Mr. MARUTHA RAJAMOULI came with c/o fever associated with Submandibular swelling. All necessary investigations were done and diagnosed as UNCONTROLLED DIABETES MELLITUS. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

- 1) TAB. ZERODOL- P TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 2) TAB. DOXT 100 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 3) TAB. ECOSPRIN 150/20 MG ONCE DAILY AT 2PM TO CONTINUE
- 4) TAB. PAN 40 MG ONCE DAILY AT 7AM BBD FOR 7 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD



ARH1.0001232626

**Name**

Mrs. P LEELA

**Patient Identifier**

ARHIP56364

**Age**

56Yr  
0Mth  
2Days

**Sex**

Female

**Date of Admission**

27-Jun-2022

**Date of Discharge  
MLC No**

**Address**

MUDHIMANIKYAM,CHIGURUMAMIDI,Karimnagar,Telangana

**Ward/  
Bed No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:101  
A

**Primary Consultant**

DR. SRI KARAN UDDESH --

## DRUG OVERDOSE

Alleged history of consumption of Methylcobalamin and some other tablets on 26/06/2022

AT ADMISSION:

PR: 91/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 56 years old female patient Mrs. P LEELA came with above mentioned complaints. Patient diagnosed as DRUG OVERDOSE . Treated with Inj Pan, Emset and IV fluids. Psychiatrist consultation taken and advice followed.

Now patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB. MIRTAZ 7.5 MG ONCE **IN A DAY AT 8 PM** FOR 7 DAYS
2. TAB. LONAZEP 0.5 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001232576

**Name**

Mr. M SATHAIAH

**Patient Identifier**

ARHIP56339

**Age**

70Yr  
0Mth  
4Days

**Sex**

Male

**Date of Admission**

25-Jun-2022

**Date of Discharge  
MLC No**

**Address**

MANKAMMA  
THOTA,Karimnagar,Telangana

**Ward/  
Bed No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:103  
A

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, STABLE ANGINA, TMT POSITIVE

NORMAL LV FUNCTION, EF-60%

R/F: T2DM

CORONARY ANGIOGRAM DONE ON 25/06/2022 – CAD-2VD (LAD, RCA)

PTCA+DES TO D1 WITH 2.25 X 28 MM XIENCE XPEDITION DONE ON 25/06/2022  
MEDICAL MANAGEMENT FOR PDA (THIN VESSEL)

C/o Retrosternal chest pain since 4 days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 70 years old male patient Mr. SATHAIAH came with c/o retrosternal chest pain since 4 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, STABLE ANGINA, TMT POSITIVE, NORMAL LV FUNCTION, EF-60%, CORONARY ANGIOGRAM DONE ON 25/06/2022 - CAD-2VD (LAD, RCA), PTCA+DES TO D1 WITH 2.25 X 28 MM XIENCE XPEDITION DONE ON 25/06/2022, MEDICAL MANAGEMENT FOR PDA (THIN VESSEL). Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. AX CER 90MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. BETALOC 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 5) TAB. OMLEZEST 20 MG ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. AMARYL MV2 ONCE DAILY AT 8AM TO CONTINUE.
- 7) TAB. ELTROXIN 100 MCG ONCE DAILY AT 7AM BBF TO CONTINUE.
- 8) TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.



--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001214254

**Name**

Mr. ABDUL  
QAYYUM

**Patient  
Identifier**

ARHIP56355

**Age**

53Yr  
0Mth  
14Days

**Sex**

Male

**Date of  
Admission**

26-Jun-  
2022

**Date of  
Discharge  
MLC No**

**Address**

manakondur,Karimnagar,Telangana

**Ward/  
Bed No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:116  
A

**Primary  
Consultant**

Dr. RAMCHANDER TORREM

ACUTE ON CHRONIC KIDNEY DISEASE  
PULMONARY OEDEMA  
HYPONATRAEMIA  
CAD, DIABETIC MELLITUS, HYPERTENSION

C/o fever, vomiting, loose motions and severe shortness of breath grade- III and generalised weakness

Known case of hypertension, diabetes mellitus and chronic kidney disease

S/P Bladder neck incision 14/06/22

AT ADMISSION:

PR: 108/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 100% with 2Ltr O2

P/A: Soft

A 53 years old male patient Mr. ABDUL QAYYUM came with c/o fever, vomiting, loose motions and severe shortness of breath grade- III and generalised weakness. All necessary investigations were done and diagnosed as ACUTE ON CHRONIC KIDNEY DISEASE, PULMONARY OEDEMA , HYPONATRAEMIA, CAD, DIABETIC MELLITUS, HYPERTENSION. Managed conservatively. Urologist consultation taken and advice followed. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

#### DISCHARGE MEDICATION:

1. TAB. GLEVO 500 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. DYTOR 20MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. METOZ 10 MG ONCE DAILY AT 8AM TO CONTINUE.
4. TAB. KETOCHECK **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. CUDCE **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. ROSA GOLD ONCE DAILY AT 2PM TO CONTINUE.
7. TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS
8. TAB. GEROZ-LP THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 10 DAYS
9. TAB. SOBINIX DS ONCE DAILY AT 2PM TO CONTINUE.
10. TAB. URIMAX 0.4 MG ONCE DAILY AT 8PM TO CONTINUE.
11. SALTED BUTTER MILK 200 ml QID FOR 10 DAYS

REVIEW AFTER 7 DAYS TO NEPHROLOGY OPD

ARH1.0001229381	<b>Name</b>		Mr. K MANOHAR	
<b>Patient Identifier</b>		ARHIP56391	<b>Age</b>	62Yr 3Mth 1Days
<b>Sex</b>		Male	<b>Date of Admission</b>	28-Jun-2022
<b>Date of Discharge</b>				
<b>MLC No</b>				
<b>Address</b>			<b>Ward/Bed No</b>	First Floor, RECOVERY ROOM, Bed no:RR 10
THANGALLAPALLY,Karimnagar,Telangana				

<b>Primary Consultant</b> Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)--GENERAL SURGERY	<b>Consultants</b>					
<b>Surgeons</b> Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)--GENERAL SURGERY	<b>Anesthesiologists</b> Dr Subba Reddy Kuppannagari--ANAESTHESIOLOGY					
<input type="checkbox"/> Diagnosis						
<b>Diagnosis</b>						
<a href="#">Add Diagnosis</a>						
<input type="checkbox"/> Surgery / Procedures Done						
<b>Surgery / Procedure</b>						
<table border="1"> <thead> <tr> <th>Surgery / Procedure Name</th> <th>Start Date</th> <th>End Date</th> <th>Surgeons</th> <th>Anesth</th> </tr> </thead> </table>		Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesth
Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesth		

FISSURE IN ANO WITH GRADE -III INTERNAL HAEMORRHOIDS  
 SURGERY: LATERAL ANAL SPHINCTEROTOMY+,HEMORRHOIDECTOMY DONE ON 28/06/2022

C/o per rectum bleeding, mild constipation since 1 month

PHYSICAL EXAMINATION:

## ON ADMISSION

-----

Pt c/c/c

afebrile

PR-82/min

BP-110/70mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

SPO2-100%

A 62 yrs old male patient Mr. MANOHAR came with c/o per rectum bleeding, mild constipation since 1 month. All necessary investigations done and diagnosed as FISSURE IN ANO WITH GRADE -III INTERNAL HAEMORRHOIDS, SURGERY: LATERAL ANAL SPHINCTEROTOMY+,HEMORRHOIDECTOMY DONE ON 28/06/2022. Findings: Grade-III internal hemorrhoids noted in the anal canal @ 3'O clock in position, posterior fissure in ano. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

### Discharge Medication:

1. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
2. TAB: ND Q10 ONCE DAILY AT 2PM FOR 30 DAYS.
3. GLUTAVALT -V SACHETS ONCE DAILY AT 8AM WITH GLASS OF WATER FOR 15 DAYS.
4. SYP. LACTIFIBER 3 TSP ONCE IN A DAY AT 8 PM
5. XYLOCAINE JELLY EVERY 4<sup>th</sup> hrly

6. METROGYL-P OINTMENT L/A THRICE DAILY AT 8AM 2PM 8PM
7. SITZ BATH THRICE DAILY

Review after 10 days in General Surgery OPD.

ARH1.0001232540

**Name**

Mr. CHENDRAMOULI BETHI

**Patient Identifier**

ARHIP56328

**Age**

70Yr 0Mth 5Days

**Sex**

Male

**Date of Admission**

24-Jun-2022

**Date of Discharge**  
**MLC No**

**Address**

h-no:7-5-251,gm colony  
godavarikhani,peddapalli,Other,Telangana

**Ward/Bed No**

Second Floor, Semi  
Private, Bed no:111  
B

**Primary Consultant**

DR. SRI KARAN UDDESH -

HFREF/AOCKD

ATRIAL FLUTTER

C/o right sided weakness since 4 days  
Shortness of breath grade-III

Known case of hypertension, diabetic mellitus

AT ADMISSION:

PR: 90/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 19/min

SPO2: 98%

P/A: Soft

A 70 years old male patient Mr. CHENDRAMOULI came with above mentioned complaints. Patient diagnosed as HFREF/AOCKD, ATRIAL FLUTTER. Treated with Inj Lasix, Heparin, Pan and other supportive medications. Nephrologist consultation taken and advice followed. Now patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB. NODOSIS 500 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS
2. TAB. SHELICAL-D ONCE **IN A DAY AT 2 PM** FOR 7 DAYS
3. TAB. SEVELAMER 800 MG THRICE **IN A DAY AT 8AM 2 PM 8PM** FOR 7 DAYS
4. TAB. KETO CHECK **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS
5. TAB. MET-XL 50 MG ONCE **IN A DAY AT 8 AM** FOR 7 DAYS
6. TAB. WARFARIN 2 MG ONCE **IN A DAY AT 8 AM** FOR 7 DAYS
7. TAB. LASIX 20 MG ONCE **IN A DAY AT 8 AM** FOR 7 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD



ARH1.0001232595

**Name**

Mr. RAVINDER P

**Patient Identifier**

ARHIP56351

**Age**

53Yr 0Mth 3Days

**Sex**

Male

**Date of Admission**

26-Jun-2022

**Date of Discharge**

**MLC No**

**Address**

KOURTALA,Karimnagar,Telangana

**Ward/Bed No**

First Floor, CICU , Bed no:CICU11

**Primary Consultant**

Dr. KRISHNA CHAITANYA M (MD,D

CORONARY ARTERY DISEASE, ACUTE AWTMI, SR

MILD LV DYSFUNCTION, EF-45%

CORONARY ANGIOGRAM DONE ON 26/06/2022 - CAD-DVD (LAD, LCX)

PTCA+DES TO LAD, LCX [ LAD WITH 2.75 X 40 MM 3V ASTRA, LCX WITH 2.5 X 36 MM]  
DONE ON 26/06/2022

C/o chest pain since 3 days

AT ADMISSION:

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 53years old male patient Mr. RAVINDER came with c/o chest pain since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, SR, MILD LV DYSFUNCTION, EF-45%, CORONARY ANGIOGRAM DONE ON 26/06/2022 – CAD-DVD (LAD, LCX), PTCA+DES TO LAD, LCX [ LAD WITH 2.75 X 40 MM 3V ASTRA, LCX WITH 2.5 X 36 MM] DONE ON 26/06/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. PAN 40MG ONCE DAILY AT 7AM BBF FOR 10 DAYS
- 4) TAB. ATORVA 80MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. NIKORAN 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 6) TAB. NITROCONTIN 2.6 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 7) TAB. FLAVEDAN MR 35 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 8) TAB. MET-XL 50MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH CBC, RP-2 REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001232471

**Name**

Mrs. RAJAMANI  
RASABAKTHULA

**Patient  
Identifier**

ARHIP56310

**Sex**

Female

**Date of  
Discharge  
MLC No**

**Address**

8-59,  
GOPALRAOPET, PEDDAPALLI, Karimnagar, Telangana

**Primary  
Consultant**

Dr. Vidya Sagar A--C

**Age**

52Yr 5Mth 6Days

**Date of  
Admission**

24-Jun-2022

**Ward/Bed  
No**

Second Floor,  
Female General  
Ward, Bed no:GW  
7

CORONARY ARTERY DISEASE, NSTEMI, SR

NORMAL LV FUNCTION [EF-60%]

CORONARY ANGIOGRAM (28/06/2022) - CAD- Mid LAD -Mild Stenosis and  
Diagonal Ostial Stenosis

PLAN MEDICAL MANAGEMENT

R/F : HTN

C/o chest pain a/w sweating since 3 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 73/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 52 years old female patient Mrs. RAJAMANI RASABAKTHULA came with c/o chest pain a/w sweating since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, NORMAL LV FUNCTION [EF-60%], CORONARY ANGIOGRAM (28/06/2022) - CAD- Mid LAD -Mild Stenosis and Diagonal Ostial Stenosis, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

#### DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.
5. TAB. CHYMORAL FORTE **TWICE IN A DAY AT 8 AM 8 PM** FOR 3 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001232542

**Name**

Mr. MATTA  
ASHRITH  
REDDY

**Patient Identifier** ARHIP56333

**Age** 13Yr 0Mth 5Days

**Sex** Male

**Date of Admission** 24-Jun-2022

**Date of Discharge**

**MLC No**

**Address** H.NO:4-18/2,KATNEPALLY,PEDDAPALLY,Karimnagar,Telangana

**Ward/Bed No** Second Floor, Male General Ward, Bed no:GW 21

**Primary Consultant** Dr. Iftekarali (MS (Orthopaedics),Consultant Orthopaedic Surgeon)--ORTHOPAEDICS

**Consultants**

**Surgeons** Dr. Iftekarali (MS (Orthopaedics),Consultant Orthopaedic Surgeon)--ORTHOPAEDICS

**Anesthesiologists** Dr Subba Reddy Kuppannagari--ANAESTHESIOLOGY

☐ **Diagnosis**

**Diagnosis**

[Add Diagnosis](#)

☐ **Surgery / Procedures Done**

**Surgery / Procedure**

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anest
LT ORIF WITH RUSH NAILING RADIUS AND ULNA,				

CLOSED FRACTURE BOTH BONE FOREARM LEFT

SURGERY: ORIF WITH RUSH NAILING RADIUS AND ULNA DONE ON 25/06/2022

Alleged to have sustained injury due to slip and fall on 23/06/22 around 3:30 p.m, sustained injury to left forearm

## PHYSICAL EXAMINATION:

### ON ADMISSION

-----  
afebrile  
PR-87/min  
BP-100/70mmhg  
RR-20/min  
RS-BAE+  
CVS-S1S2+  
P/A-Soft  
SPO2-99%

A 13 years old male patient Mr. MATTA ASHRITH REDDY came with alleged to have sustained injury due to slip and fall on 23/06/22 around 3:30 p.m, sustained injury to left forearm. All necessary investigations were done and diagnosed as CLOSED FRACTURE BOTH BONE FOREARM LEFT, SURGERY: ORIF WITH RUSH NAILING RADIUS AND ULNA DONE ON 25/06/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence she is being discharged with required medication and advice.

## DISCHARGE MEDICATION:

- 
1. TAB. TROUFIZ 500MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
  2. TAB. VOVERAN SR TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
  3. TAB. KYLID RD ONCE DAILY AT 8AM FOR 7 DAYS.
  4. TAB. OSTOCAL ONCE DAILY AT 2PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO DR. IFTEKARALI SIR OPD.

ARH1.0001232487

<b>Name</b>		Mr. SRINIVAS BATTULA	
<b>Patient Identifier</b>	ARHIP56311	<b>Age</b>	39Yr 0Mth 6Days
<b>Sex</b>	Male	<b>Date of Admission</b>	24-Jun-2022
<b>Date of Discharge MLC No</b>			
<b>Address</b>	28-87 CHERIYALA,Karimnagar,Telangana	<b>Ward/ Bed No</b>	Second Floor, Male General Ward, Bed no:GW 19
<b>Primary Consultant</b>	Dr. Iftekarali (MS (Orthopaedics		

CLOSED FRACTURE BOTH BONES FOREARM RIGHT

SURGERY: ORIF WITH DCP RADIUS AND ULNA RT DONE ON 25/06/2022

Alleged to have sustained injury due to slip and fall on 24/06/22 around 7:30 p.m, sustained injury to left forearm

#### PHYSICAL EXAMINATION:

##### ON ADMISSION

-----  
afebrile  
PR-82/min  
BP-110/70mmhg  
RR-20/min  
RS-BAE+  
CVS-S1S2+  
P/A-Soft  
SPO2-98%



A 39 years old male patient Mr. SRINIVAS BATTULA came with alleged to have sustained injury due to slip and fall on 24/06/22 around 7:30 p.m, sustained injury to left forearm. All necessary investigations were done and diagnosed as CLOSED FRACTURE BOTH BONES FOREARM RIGHT, SURGERY: ORIF WITH DCP RADIUS AND ULNA RT DONE ON 25/06/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence she is being discharged with required medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB. TROUFIZ 500MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
2. TAB. VOVERAN 50 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
3. TAB. KYLID RD ONCE DAILY AT 8AM FOR 7 DAYS.
4. TAB. OSTOCAL ONCE DAILY AT 2PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO DR. IFTEKARALI SIR OPD.

ARH1.0001230249

**Name**

Mr. M BUCHAIAH

**Patient Identifier**

ARHIP56370

**Age**

77Yr  
2Mth  
4Days

**Sex**

Male

**Date of Admission**

27-Jun-2022

**Date of Discharge  
MLC No**

**Address**

Jyothinagar,Karimnagar,Telangana

**Ward/  
Bed No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:122  
B

**Primary Consultant**

Dr. GOUTHAM ROY (MS

LEFT INGUINAL DIRECT HERNIA

SURGERY: LEFT INGUINAL HERNIOPLASTY DONE ON 28/06/2022

C/o swelling in left inguinal region since 1 month  
K/c/o HTN, T2DM

#### PHYSICAL EXAMINATION:

##### ON ADMISSION

-----

Pt c/c/c

afebrile

PR-86/min

BP-100/60mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

SPO2-98%

A 77 yrs old male patient Mr. BUCHAIAH came with c/o swelling in left inguinal region since 1 month. All necessary investigations done and diagnosed as LEFT INGUINAL DIRECT HERNIA , SURGERY: LEFT INGUINAL HERNIOPLASTY DONE ON 28/06/2022. Findings: 2 cm above inguinal ligament, Direct defect noted. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ROXSAFE 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. GLUTAVULT SACHETS ONCE DAILY AT 8AM WITH GLASS OF WATER FOR 15 DAYS.

Review after 10 days in General Surgery OPD.

ARH1.0001232483		Name	Mr. SHAIK HUSSUN BEE
Patient Identifier	ARHIP56313	Age	76Yr 0Mth 6Days
Sex	Male	Date of Admission	24-Jun-2022
Date of Discharge			
MLC No			
Address	Other,Other	Ward/Bed No	Second Floor, Female General Ward, Bed no:GW 4

**Primary Consultant**

Dr. Iftekarali (MS  
(Orthopaedics),Consultant  
Orthopaedic  
Surgeon)--  
ORTHOPAEDICS

**Consultants**

**Surgeons**

Dr. Iftekarali (MS  
(Orthopaedics),Consultant  
Orthopaedic  
Surgeon)--  
ORTHOPAEDICS

**Anesthesiologists**

Dr Subba Reddy  
Kuppannagari--  
ANAESTHESIOLOGY

☐ **Diagnosis**

**Diagnosis**

[Add  
Diagnosis](#)

ARHIP56313

ARH1.000123248

☐ **Surgery / Procedures  
Done**

**Surgery / Procedure**

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
HEMIORTHOPLASTY WITH AMP LT				

INTRACAPSULAR FRACTURE NECK OF FEMUR LEFT

SURGERY: AMP LEFT DONE ON 25/06/2022

Alleged to have sustained injury due to slip and fall on 21/06/22, sustained injury to left hip

**PHYSICAL EXAMINATION:**

**ON ADMISSION**

-----

afebrile

PR-104/min

BP-100/60mmhg

RR-20/min

RS-BAE+  
CVS-S1S2+  
P/A-Soft  
SPO2-98%

A 76 years old male patient Mr. SHAIK HUSSUN BEE came with h/o alleged to have sustained injury due to slip and fall on 21/06/22, sustained injury to left hip. All necessary investigations were done and diagnosed as INTRACAPSULAR FRACTURE NECK OF FEMUR LEFT, SURGERY: AMP LEFT DONE ON 25/06/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence she is being discharged with required medication and advice.

DISCHARGE MEDICATION:

- 
1. TAB. TROUFIZ 500MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
  2. TAB. VOVERAN 50 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
  3. TAB. KYLID RD ONCE DAILY AT 8AM FOR 7 DAYS.
  4. TAB. OSTOCAL ONCE DAILY AT 2PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO DR. IFTEKARALI SIR OPD.

ARH1.0001174674

**Name**

Mr. RAJAM  
CH

**Patient Identifier**

ARHIP56222

**Age**

59Yr  
2Mth  
19Days

**Sex**

Male

**Date of Admission**

18-Jun-2022

**Date of Discharge  
MLC No**

**Address**

PENCHIKALAPET,KAMANPUR,Karimnagar,Telangana

**Ward/  
Bed No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:117  
B

**Primary Consultant**

Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant-  
Cardio Thoracic & Vascular Surgeon)--C T  
SURGERY

CORONARY ARTERY DISEASE, DOUBLE VESSEL DISEASE, S/P ISR OF LAD + IWMI+ LV DYS  
FUNCTION+ HTN

SURGERY -CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD] DONE ON 22/06/2022.

C/o retrosternal chest pain a/w sweating since 3 days

K/c/o HTN

ON ADMISSION VITAL

-----

Patient conscious, coherent

Afebrile

PR-80/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 59 years old male patient Mr. RAJAM presented to hospital with c/o retrosternal chest pain a/w sweating since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, DOUBLE VESSEL DISEASE, S/P ISR OF LAD + IWMi+ LV DYS FUNCTION+ HTN, SURGERY –CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD] DONE ON 22/06/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, PARADOXICAL SEPTAL MOTION, MILD LV DYSFUNCTION, NO PE/CLOT/VEG

BMI is 21.1 kg/m<sup>2</sup>.

Sr. Creatinine report on 23.06.2022 0.8 mg/dl.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. ND-VIT ONCE DAILY AT 2PM TO CONTINUE.
- 4) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 6) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.
- 7) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.
- 8) TAB. TRAMADOL 50MG THRICE DAILY AT 8AM 2PM 8PM FOR 5 DAYS.
- 9) TAB. PROLOMET XL 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 10) TAB. ALPRAX 0.25 MG ONCE DAILY AT 8PM FOR 5 DAYS.
- 11) SYP. CREMAFFIN 15 ml THRICE DAILY AT 8AM 2PM 8PM .

REVIEW AFTER 11 DAYS TO CTVS OPD



ARH1.0001232423

**Name**

Baby  
VARSHINI  
DAMA

**Patient Identifier**

ARHIP56284

**Age**

8Yr  
0Mth  
7Days

**Sex**

Female

**Date of  
Admission**

22-Jun-  
2022

**Date of Discharge  
MLC No**

**Address**

KORUTLA,JAGTIAL,Karimnagar,Telanga  
na

**Ward/  
Bed No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:122  
A

**Primary Consultant**

Dr SOMASHEKAR K(

CAHD WITH OS ASD WITH L-R SHUNT WITH EMBOLISM OF ASD DEVICE IN PA  
Surgery: SURGICAL CLOSURE WITH AUTOLOGUS PERICARDIAL PATCH WITH RETRIEVAL OF ASD DEVICE  
FROM PA DONE ON 22/06/2021.

C/o shortness of breath, palpitations for 1 month

#### ON ADMISSION VITAL

-----  
Patient conscious, coherent  
Afebrile  
PR-88/min  
BP-110/70mmhg  
RR-18/min  
RS-BAE+,  
CVS-S1S2+  
P/A-Soft, BS+  
SPO2-99%

A 08 years old female Baby VARSHINI DAMA presented to hospital with c/o shortness of breath, palpitations for 1 month. All necessary investigations were done and diagnosed as CAHD WITH OS ASD WITH L-R SHUNT WITH EMBOLISM OF ASD DEVICE IN PA, Surgery: SURGICAL CLOSURE WITH AUTOLOGUS PERICARDIAL PATCH WITH RETRIEVAL OF ASD DEVICE FROM PA DONE ON 22/06/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence she is being discharged with required medication and advice.

POST ASD 2D ECHO REPORT: ASD SURGICAL CLOSURE, PATCH INSITU, NORMAL LV/RV FUNCTION, NO PE/CLOT/VEG EF-62%.

BMI is 13.8 kg/m2.

Sr. Creatinine report on 23/06/2022 0.6 mg/dl.

#### DISCHARGE MEDICATION

- 1) TAB. DYTOR PLUS 5 MG ONCE DAILY AT 8AM TO CONTINUE.  
2) TAB. DIXIN 0.25 MG ONCE DAILY AT 8AM TO CONTINUE.

- 3) TAB. ROXSAFE 375 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.
- 4) SYP ASCORIL-D ½ tsp THRICE DAILY AT 8AM 2PM 8PM

REVIEW AFTER 11 DAYS TO CTVS OPD.

ARH1.0001185733

**Name**

Mrs. A LAXMI

**Patient Identifier**

ARHIP56309

**Age**

56Yr  
5Mth  
28Days

**Sex**

Female

**Date of Admission**

23-Jun-2022

**Date of Discharge  
MLC No**

**Address**

1-10/1,KESLAPUR,Mancheria,Telangana

**Ward/Bed No**

Second Floor,  
Female General Ward,  
Bed no:GW 6

**Primary Consultant**

DR. SANJAY KUMAR KAMINWAR

CVA-ACUTE LEFT MCA INFARCT

C/o weakness of right upper limb and lower limb, slurring of speech.

ON ADMISSION

-----

Pt c/c/c

Afebrile

PR-98/min

BP-110/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft, BS+

SPO2-98%

A 56 years old female patient Mrs. LAXMI presented to hospital with c/o weakness of right upper limb and lower limb, slurring of speech.. All necessary investigations were done and diagnosed as CVA- ACUTE LEFT MCA INFARCT. Patient was treated conservatively and improved symptomatically. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

- 1) TAB. PREVA AS 75MG 1TAB AT 2PM TO CONTINUE.
- 2) TAB. COLTRO 10MG 1TAB AT 9PM TO CONTINUE.

REVIEW AFTER 11 DAYS TO DR. SANJAY KUMAR KAMINWAR OPD.

ARH1.0001232  
714

**Name**

Mr.  
SANG  
A  
ODEL  
U

**Patient  
Identifier** ARHIP56400

**Age** 50Yr  
0Mth  
0Days

**Sex** Male

**Date of  
Admission** 29-Jun-  
2022

**Date of  
Discharge  
MLC No**

**Address** RAJARAMPALLY,VELGATUR,JAGTIAL,Karimnagar,Telangana

**Ward/  
Bed No** Ground  
Floor,  
Emergency Ward,  
Bed  
no:EME2

**Primary  
Consultant** Dr. GOUTHAM ROY (MS)

LEFT TEMPORAL SEBACEOUS CYST  
SURGERY: LEFT TEMPORAL SEBACEOUS CYST DONE ON 29.06.2022

C/o swelling in left temporal region

PHYSICAL EXAMINATION:

ON ADMISSION

-----

Pt c/c/c

afebrile

PR-80/min

BP-120/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 50 yr old male patient MR. SANGA ODELU came with c/o swelling in left temporal region. All necessary investigations done and diagnosed as LEFT TEMPORAL SEBACEOUS CYST, SURGERY: LEFT TEMPORAL SEBACEOUS CYST DONE ON 29.06.2022. Findings: Cyst measuring 2 x 2 cm noted in the left temporal region. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. TAB: FAMOCID 40 MG TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
5. GLUTAVULT SACHETS ONCE DAILY AT 2PM FOR 15 DAYS.

Review after 7 days in General Surgery OPD.

ARH1.0001232699

	<b>Name</b>	Mr. DASARI RAVI	
<b>Patient</b>	ARHIP56396	<b>Age</b>	34Yr

Identifier

SexMale

Date of Discharge

MLC No

AddressRAJARAMPALLY,Telangana

Primary ConsultantDr Chandra Shekar Sathineni(MD (Internal Medicine) )--INTERNAL MEDICINE

Surgeons

Date of Admission0Mth 2Days 28-Jun-2022

Ward/Bed NoFirst Floor, MICU, Bed no:MIC U 2

Consultants

Anesthesiologists

Diagnosis

Diagnosi

S

Disease	Disease Type
SUICIDAL HERBICIDAL POISONING.	

[illegible]

Mr. SUDDALA  
GANGA REDDY

ARHIP56255

53Yr  
0Mth  
16Day  
S

**Sex**

Male

**Date of Admission** 20-Jun-2022

**Date of Discharge**  
**MLC No**

### Address

GANGADHARA  
UPPERMALLIAL,Karimnagar,Telangana

Ward/  
Bed No

First  
Floor,  
CT  
POST,  
Bed  
no:CT  
2

### Primary Consultant

Dr SOMASHEKAR K(MS,MCH

## CRHD + SEVERE MITRAL RESTENOSIS

SURGERY: MVR WITH TTKC NO. 31 MM MECHANICAL VALVE DONE ON 24/06/2022

ON POST POD 5<sup>TH</sup>: SEPTIC SHOCK WITH NON-OLIGURIC AKI + CARDIOEMBOLIC STROKE

C/o SOB on exertion a/w palpitations since 3 days

AT ADMISSION:

Afebrile

PR: 82/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft



A 53 years old male patient Mr. SUDDALA GANGA REDDY came with c/o SOB on exertion a/w palpitations since 3 days. All necessary investigations were done and diagnosed as CRHD + SEVERE MITRAL RESTENOSIS, SURGERY: MVR WITH TTKC NO. 31 MM MECHANICAL VALVE DONE ON 24/06/2022. ON POST POD 5<sup>TH</sup>: SEPTIC SHOCK WITH NON-OLIGURIC AKI + CARDIOEMBOLIC STROKE

0-POD: was uneventful

1<sup>st</sup> POD: patient was extubated at 6.15 AM

2<sup>nd</sup> POD : was uneventful

3<sup>rd</sup> POD : patient developed fever

Hb 7.7 gm/dl - 1 Unit PCV transfusion done Hb improved to 9.5 gm/dl

4<sup>th</sup> POD : Patient had facial weakness and unable to swallow

5<sup>th</sup> POD : patient developed left lower limb and upper limb weakness for which neurophysician consultation was done, CT was normal hence MRI brain was advised and diagnosed as cardioembolic stroke, post MVR and treated accordingly.

In view of fever, increased Sr. Urea & Creatinine, Nephrologist consultation was done and diagnosed as septic shock with non-oliguric AKI, 1 session haemodialysis done and treated accordingly.

In view of fever of unknown origin Cardiologist opinion was taken and advised TEE for identifying mass in LA, LV, PV to rule out PV vegetations and infective endocarditis- TEE was not done.

Poor prognosis explained to the patient attendants. Patient attendants requested for discharge, hence patient is being discharged under LAMA.

Urine c/s - negative

Blood c/s report awaited

Medications given in the hospital:

INJ CLINDAMYCIN

INJ VANCOMYCIN

INJ DERIPHYLLIN

INJ STROCID

INJ PARACIP

TAB RIFAMPICIN

TAB TONACT

TAB FAMOCID

TAB ACITROM

TAB DYTOR

TAB ND VIT

TAB CARDARONE

TAB MET XL

INJ HUMAN MIXTARD

INJ POTASSIUM CHLORIDE

INJ CALCIUM

NEB WITH DUOLIN/BUDECORT

ARH1.0001232699

**Name**

Mr. DASARI RAVI

**Patient Identifier**

ARHIP56396

**Age**

34Yr  
0Mth  
2Days

**Sex**

Male

**Date of Admission**

28-Jun-2022

**Date of Discharge**  
**MLC No**

**Address**

RAJARAMPALLY,Telangana

**Ward/Bed No**

First  
Floor,  
MICU,  
Bed  
no:MIC  
U 2

**Primary Consultant**

Dr Chandra Shekar Sathineni(MD  
(Internal Medicine) )--INTERNAL  
MEDICINE

**Consultants**

**Surgeons**

**Anesthesiologists**

Diagnosis

**Diagnosis**

Disease	Disease Type
SUICIDAL HERBICIDAL POISONING.	

HERBICIDAL POISONING

Alleged history of consumption of herbicidal poisoning around 8:00 p.m. on 28/06/2022

AT ADMISSION:

Afebrile

PR: 98/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 34 years old male patient Mr. DASARI RAVI came with alleged history of consumption of herbicidal poisoning around 8:00 p.m. on 28/06/2022. All necessary investigations were done and diagnosed as HERBICIDAL POISONING. Managed conservatively. Patient attendants requested for discharge, hence patient is being discharged at request.

Mr. DASARI RAVI

DISCHARGE MEDICATION:

-----

1) TAB. TAXIM-O 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

2) TAB. PAN-D ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.

3) TAB. HEADNEURON ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 5 DAYS IN GENERAL MEDICINE OPD

ARH1.0001232609

**Name**

Mrs.  
MAHAMMA  
D  
SHAMEEM

**Patient Identifier**

ARHIP56360

**Age**

65Yr  
0Mth  
4Days

**Sex**

Female

**Date of  
Admission**

27-Jun-  
2022

**Date of Discharge  
MLC No**

**Address**

4-74 SADAK  
GUDA,Adilabad(Adilabad),Telangana

**Ward/Bed  
No**

Second  
Floor,  
Female  
General Ward,  
Bed  
no:GW  
11

**Primary Consultant**

Dr. KRISHNA CHAITANYA

CAD, IPWMI

MINOR CAD

FAIR LV FUNCTION

NO HF

SR

C/o left side chest pain since 4-5 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 64/min

BP: 90/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 65 years old female patient Mrs. MAHAMMAD SHAMEEM resented with a history of chest pain. On evaluation on Trop-T positive was diagnosed as NSTEMI. CAG done showed minor CAD. Her medications were optimised. Hence being discharged with the following medication.

**DISCHARGE MEDICATION:**

1. TAB. ECOSPRIN AV 75/10 ONCE IN A DAY AT 9 P.M. TO CONTINUE

**REVIEW AFTER 11 DAYS TO CARDIAC OPD**

ARH1.0001188  
989

**Name** Mr.  
RANGANAYAKU  
LA RAMESH

**Patient Identifier** ARHIP56362

**Age** 49Yr 2Mth  
20Days

**Sex** Male

**Date of Admission** 27-Jun-2022

**Date of Discharge**

**MLC No**

**Address** 9-5-193/1/A,SHIVA  
NAGAR, RAMNAGAR, KARIMNAGAR, Karimnagar, T  
elangana

**Ward/Bed No** Second Floor,  
Semi Private, Bed  
no:116 B

**Primary Consultant** Dr. SURESH GOUD S(MS,M.Ch  
Urology(SVIMS),Consultant Urologist)--UROLOGY

**Consultants**

**Surgeons**

Dr. SURESH GOUD S(MS,M.Ch  
Urology(SVIMS),Consultant Urologist)--UROLOGY

**Anesthesiologists**

Dr Subba Reddy  
Kuppannagari--  
ANAESTHESIOLOGY

☐ **Diagnosis**

**Diagnosis**

[Add  
Diagnosis](#)

ARHIP56362	ARH1.000118896
------------	----------------

☐ **Surgery / Procedures  
Done**

**Surgery / Procedure**

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
LEFT PUSH BACK PCNL AND DJ STENTING				

LEFT PROXIMAL URETERIC CALCULUS  
SURGERY : LEFT PUSH BACK PCNL + DJ STENTING DONE ON 27.06.2022

C/o left loin pain, burning micturition since 10 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

All required investigations done and enclosed

A 27 yrs old male patient Mr. NILAM RAJU came to the hospital with c/o left loin pain, burning micturition since 10 days. All necessary investigations done and diagnosed as LEFT PROXIMAL URETERIC CALCULUS, SURGERY : LEFT PUSH BACK PCNL AND DJ STENTING DONE ON 31.05.2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice. Patient explained for stent removal after 3 weeks.

DISCHARGE MEDICATION:

-----

1. TAB: ROXSAFE CV 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.



2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: PAN 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: NDQ10 ONCE DAILY AT 2PM FOR 10 DAYS
5. TAB: VELTOM 2.4 MG ONCE DAILY AT 8PM FOR 10 DAYS
6. SYP. K-CIT 10 ML **TWICE IN A DAY AT 8 AM 8 PM**

REVIEW AFTER 7 DAYS TO UROLOGY OPD, STENT REMOVAL AFTER 3 WEEKS

ARH1.0001232591

**Name**

Mr. T RAKESH

**Patient Identifier**

ARHIP56347

**Age**

34Yr  
0Mth  
5Days

**Sex**

Male

**Date of Admission**

25-Jun-2022

**Date of Discharge  
MLC No**

**Address**

GATLANARSINGAPUR  
BHEEMADEVARAPALLI, Karimnagar, Telangana

**Ward/  
Bed No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:119  
B

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

## PULMONARY ARTERY HYPERTENSION

C/o shortness of breath grade-III since 2-3 days  
pain abdomen  
Fever with headache  
chest pain associated with cough

### AT ADMISSION:

Afebrile

PR: 86/min

BP: 100/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 34 years old male patient Mr. RAKESH presented with c/o shortness of breath grade-III since 2-3 days, pain abdomen, fever with headache, chest pain associated with cough. All necessary investigations were done and diagnosed as PULMONARY ARTERY HYPERTENSION. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. PAH 20 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB. BENALGIS 100 MG ONCE DAILY AT 2PM FOR 7 DAYS.
3. CAP. BEVON ONCE DAILY AT 2PM FOR 7 DAYS.
4. TAB. PANTOCID 40 MG ONCE DAILY AT 8AM FOR 7 DAYS.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001232642

**Name**

Mrs. SUGUNA  
MADASI

**Patient  
Identifier**

ARHIP56366

**Age**

62Yr  
0Mth  
3Days

**Sex**

Female

**Date of  
Admission**

27-Jun-  
2022

**Date of  
Discharge  
MLC No**

**Address**

JAMMIKUNTA,Karimnagar,Telangana

**Ward/  
Bed No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:106  
A

**Primary  
Consultant**

Dr Chandra Shekar Sathineni

## POLYARTHRITIS

C/o multiple joint pains including temporomandibular joints

### AT ADMISSION:

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 62 years old female patient Mrs. SUGUNA MADASI came with c/o multiple joint pains including temporomandibular joints. All necessary investigations were done and diagnosed as POLYARTHRITIS. Managed conservatively. Rheumatologist consultation taken and advice followed. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

- 1) TAB. ULTRACET TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS
- 2) TAB. OMNACORTIL 5 MG  $\frac{1}{2}$  TAB ONCE DAILY AT 8PM FOR 7 DAYS.
- 3) TAB. HCQS 200 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS
- 4) TAB. SHELICAL ONCE DAILY AT 2PM FOR 7 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001232544

		Mr. PRABHAKAR REDDY KARIVEDA	
<b>Name</b>			
<b>Patient Identifier</b>	ARHIP56334	<b>Age</b>	62Yr 3Mth 0Days
<b>Sex</b>	Male	<b>Date of Admission</b>	25-Jun-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	H*NO LAXMIDEVIPALLI, Karimnagar, Telangana	<b>Ward/ Bed No</b>	Second Floor, Semi Private, Bed no:111A
<b>Primary Consultant</b>	Dr. SURESH GOUD S(		

BPH with increased S.PSA with AUR

C/o Gradually decreased urine output  
Low backache

AT ADMISSION:

Afebrile

PR: 86/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 62 years old male patient Mr. PRABHAKAR REDDY KARIVEDA came with c/o gradually decreased urine output, low backache. All necessary investigations were done and diagnosed as BPH with increased S.PSA with AUR . Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise. Trial void after 10 days, if Trial void fails, plan TURP after getting urodynamic study.

DISCHARGE MEDICATION:

- 
- 1) TAB. FAROBACT 200 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS
  - 2) TAB. URIMAX-D ONCE DAILY AT 8PM FOR 15 DAYS.
  - 3) TAB. PAN-D ONCE DAILY AT 7M BBF FOR 15 DAYS.
  - 4) TAB. DROLGAN TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS
  - 5) TAB. A TO Z GOLD ONCE DAILY AT 2PM FOR 10 DAYS
  - 6) SYP: K-CIT 10 ml TWICE DAILY AT 8AM, 8PM

REVIEW AFTER 10 DAYS IN UROLOGY OPD

ARH1.0001232214

**Name**

Mr. MALLAIAH  
RASAPALLI

**Patient  
Identifier**

ARHIP56201

**Age**

72Yr  
3Mth  
20Days

**Sex**

Male

**Date of  
Admission**

16-Jun-  
2022

**Date of  
Discharge  
MLC No**

**Address**

6-57, SOMAGUDEM,  
BELLAMPALLY,Telangana

**Ward/  
Bed No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:105  
A

**Primary  
Consultant**

Dr. RAMCHANDER TORREM(DM

URAEMIC ENCEPHALOPATHY  
ACUTE ON CHRONIC KIDNEY DISEASE  
DUODENAL ULCER  
ACUTE GI BLEED  
ACUTE POSTERIOR CIRCULATION STROKE  
HYPERTENSION, CAD, S/P PTCA

C/o Decreased food intake,  
slurring of speech  
difficulty in swallowing since 10 days

AT ADMISSION:

Afebrile

PR: 58/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 14/min

SPO2: 99%

P/A: Soft





A 72 years old male patient Mr. MALLAIAH RASAPALLI came with c/o Decreased food intake, slurring of speech, difficulty in swallowing since 10 days. All necessary investigations were done and diagnosed as URAEMIC ENCEPHALOPATHY, ACUTE ON CHRONIC KIDNEY DISEASE, DUODENAL ULCER, ACUTE GI BLEED, ACUTE POSTERIOR CIRCULATION STROKE, HYPERTENSION, CAD, S/P PTCA. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. FAROALFA 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
2. TAB. STORVAS-CV ONCE DAILY AT 2PM FOR 5 DAYS
3. TAB. KETOCHECK THRICE DAILY AT 8AM 2PM AND 8PM TO CONTINUE.
4. TAB. CUDCE FORTE THRICE DAILY AT 8AM 2PM AND 8PM TO CONTINUE.
5. TAB. THYRONORM 25 MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. CALCI-CZ ONCE DAILY AT 2PM TO CONTINUE.
7. TAB. MULTI-8 ONCE DAILY AT 2PM TO CONTINUE.
8. TAB. UBILIFE ONCE DAILY AT 2PM TO CONTINUE.
9. TAB. SOBINIX DS ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 5 DAYS IN NEPHROLOGY OPD

ARH1.0001221028

**Name**

Mr. V SRINIVAS

**Patient Identifier**

ARHIP56393

**Age**

51Yr  
9Mth  
22Days

**Sex**

Male

**Date of Admission**

28-Jun-2022

**Date of Discharge  
MLC No**

**Address**

Sulthanabad,Karimnagar,Telangana

**Ward/  
Bed No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:123  
C

**Primary Consultant**

Dr. RAMCHANDER TORREM

## ACUTE FEBRILE ILLNESS WITH SEPSIS

C/o Fever with chills, mild shortness of breath and abdominal discomfort

Known case of hypertension, diabetic mellitus, CKD on haemodialysis  
History of right lower limb cellulitis

### AT ADMISSION:

PR: 130/min

BP: 170/100mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 51 years old male patient Mr. SRINIVAS came with c/o fever with chills, mild shortness of breath and abdominal discomfort. All necessary investigations were done and diagnosed as ACUTE FEBRILE ILLNESS WITH SEPSIS. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. LINOZEM 600 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
2. TAB. GLEVO 500 MG ONCE DAILY AT 2PM FOR 5 DAYS
3. TAB. DOLO 650 MG THRICE DAILY AT 8AM 2PM AND 8PM FOR 5 DAYS.
4. TAB. CILACAR M 10/50 **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. DYTOR 40 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. METOZ 10 MG ONCE DAILY AT 2PM TO CONTINUE.
7. TAB. CALCI-CZ ONCE DAILY AT 2PM TO CONTINUE.
8. TAB. GEROZ-LP **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

REVIEW AFTER 5 DAYS IN NEPHROLOGY OPD

ARH1.0001221643

<b>Name</b>	Mr. SATYANARAYANA SAMALA		
<b>Patient Identifier</b>	ARHIP56306	<b>Age</b>	72Yr 9Mth 11Days
<b>Sex</b>	Male	<b>Date of Admission</b>	23-Jun-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	H.NO:9-8-99,T.R.NAGAR,SIRICILLA,RAJANNA SIRICILLA,Other,Telangana	<b>Ward/Bed No</b>	Second Floor, Semi Private , Bed no:115A
<b>Primary Consultant</b>	Dr Chandra Shekar Sathineni		

LOWER RESPIRATORY TRACT INFECTION  
RENAL INSUFFICIENCY  
DIABETIC MELLITUS

C/o Shortness of breath grade- 3 to 4 since 1 day associated with cough

Known case of CAD s/p CABG in 09/2021  
T2DM, HTN, AKI

AT ADMISSION:

Afebrile

PR: 160/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 72 years old male patient Mr. SATYANARAYANA SAMALA came with c/o shortness of breath grade- 3 to 4 since 1 day associated with cough. Known case of CAD s/p CABG in 09/2021, T2DM, HTN, AKI. All necessary investigations were done and diagnosed as LOWER RESPIRATORY TRACT INFECTION, RENAL INSUFFICIENCY, DIABETIC MELLITUS. Managed conservatively. Patient

condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

- 1) TAB. FPM ACT 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 2) TAB. LINOZEM 600 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 3) TAB. SOBISIS FORTE TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS
- 4) INJ. LANTUS 20 UNITS ONCE DAILY AT 8PM FOR 7 DAYS
- 5) TAB. GEROZ-LP ONCE DAILY AT 8PM FOR 10 DAYS
- 6) TAB. DYTOR PLUS 20 MG ONCE DAILY AT 8AM FOR 10 DAYS
- 7) TAB. RENOSAVE ONCE DAILY AT 2PM FOR 7 DAYS
- 8) TAB. ECOSPRIN AV 150/20 ONCE DAILY AT 8PM FOR 15 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001178051

**Name**

Mr.  
PYDAKULA  
MALLAIAH

**Patient Identifier** ARHIP56293

**Age** 67Yr  
3Mth  
0Days

**Sex** Male

**Date of Admission** 23-Jun-2022

**Date of Discharge**  
**MLC No**

**Address** 2-  
96/1, RAMANNAPALLI, JAMMIKUNTA, Karimnagar, Telangana

**Ward/ Bed No** Second Floor, Semi Private, Bed no:118C

**Primary Consultant** Dr Chandra Shekar Sathineni

RIGHT KNEE OSTEOARTHRITIS  
CERVICAL SPONDYLOSIS

C/o bilateral paraesthesia, numbness since 3-4 days  
Generalised weakness

Known case of hypertension

AT ADMISSION:

Afebrile

PR: 86/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 67 years old male patient Mr. PYDAKULA MALLAIAH came with c/o bilateral paraesthesia, numbness since 3-4 days, generalised weakness. All necessary investigations were done and diagnosed as RIGHT KNEE OSTEOARTHRITIS,

CERVICAL SPONDYLOSIS. Managed conservatively. Psychiatrist consultation taken and advice followed. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. ROSELUPIN ONCE DAILY AT 8AM FOR 7 DAYS
2. TAB. NOOTROPIL ONCE DAILY AT 2PM FOR 7 DAYS
3. TAB. LARIGABA NT TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS
4. TAB. DONEP 5 MG ONCE DAILY AT 8AM FOR 7 DAYS
5. TAB. QUITIPIN 25 MG ONCE DAILY AT 8PM FOR 7 DAYS
6. TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS
7. SYP. PREGALUP 15 ml TWICE DAILY AT 8AM AND 8PM

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD





ARH1.0001232393

<b>Name</b>	Mrs. VIJAYA LAXMI		
<b>Patient Identifier</b>	ARHIP56392	<b>Age</b>	60Yr 0Mth 9Days
<b>Sex</b>	Female	<b>Date of Admission</b>	28-Jun-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	Godavarikhani Peddapalli,Ramagundam,Telangana	<b>Ward/ Bed No</b>	First Floor, CICU , Bed no:CICU 1
<b>Primary Consultant</b>	Dr. KRISHNA CHAITANYA M (MD)		

CORONARY ARTERY DISEASE , AWSTEMI  
SEVERE LV DYSFUNCTION,  
PULMONARY EDEMA  
CARDIOGENIC SHOCK  
HEART FAILURE - CONTROLLED.  
FC-IV  
SINUS RHYTHM  
CORONARY ANGIOGRAM DONE ON 21/06/2022 - CRITICAL-LM+TVD  
CARDIAC VIABILITY: MRI: 50% VIABLE MYOCARDIUM IN LAD TERRITORY  
PLAN: CABG

C/o sudden onset chest pain since 1 day

At Admission

-----

Afebrile  
PR: 65/min  
BP: 110/70 mmHg  
RR-20/min  
RS: BAE+  
CVS: S1S2  
P/A: Soft  
SPO2-86%

A 60 years old female patient Mrs. VIJAYA LAXMI was admitted for stabilization of breathing difficulty, she was planned for CABG. Hence, being discharged for CABG with the following medication.

DISCHARGE MEDICATION:

1. TAB. ATORVA 40 MG ONCE DAILY AT 9PM TO CONTINUE.
2. TAB. RANOZEX 500MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
3. TAB. MET XL 25MG ONCE DAILY AT 8AM TO CONTINUE.
4. TAB. PAN 40MG ONCE DAILY AT 7AM BBF FOR 10 DAYS.
5. TAB. IVABID 5MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
6. TAB. FRUSELAC DS (40/50) TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
7. TAB. RAMISTAR 2.5MG ONCE DAILY AT 8AM TO CONTINUE.
8. INJ HUMAN ACTRAPOD S/C 8/5 THRICE DAILY AT 8AM 2PM 8PM
9. INJ HEPARIN 5000 Units IV 6<sup>th</sup> hrly

REVIEW AFTER 7 DAYS IN CARDIAC OPD

ARH1.00012326  
60

**Name**

Mrs. RAJA  
KUMARI  
RADHARAP  
U

**Patient  
Identifier** ARHIP56374

**Age** 65Yr  
0Mth  
3Days

**Sex** Female

**Date of  
Admission** 27-  
Jun-  
2022

**Date of  
Discharge**

**MLC No**

**Address** 13-3-  
432/2, THILAKNAGAR, GODAVARIKHANI, PEDDAPALLI, Karimnagar, Telangana

**Ward/  
Bed No** Second  
Floor,  
Semi  
Private, Bed  
no:10  
6 B

**Primary  
Consultant** DR. SRI KARAN UDDESH  
nt

## ACUTE ON CHRONIC KIDNEY DISEASE

C/o bilateral pedal oedema since 2 months

H/o facial puffiness since 1 month

Known case of diabetic mellitus hypertension and hypothyroidism on treatment

History of appendicectomy 20 years ago

### AT ADMISSION:

PR: 97/min

BP: 140/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft, b/l- pitting pedal edema

A 65 years old male patient Mrs. RAJA KUMARI RADHARAPU presented with the above-mentioned complaints, patient was suspected to have chronic kidney disease. Workup revealed hyperurecemia, hyperphosphataemia and anaemia of chronic kidney disease, patient was treated with diuretics and CALCIUM supplementation and FEBUGET. Patient is now symptomatically better and he is hence being discharged with following advice.

DISCHARGE MEDICATION:

-----

1. TAB. PAN 40 MG ONCE **IN A DAY AT 7AM** FOR 7 DAYS
2. TAB. SHELAL-O ONCE **IN A DAY AT 8 AM** FOR 7 DAYS
3. TAB. KETO CHECK **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS
4. TAB. THYRONORM 50 MCG ONCE **IN A DAY AT 8 AM** TO CONTINUE
5. TAB. FEBUGUT ONCE **IN A DAY AT 8 AM** FOR 7 DAYS
6. TAB. TELMA 20 MG ONCE **IN A DAY AT 8 AM** TO CONTINUE
7. TAB. DYTOR 20 MG ONCE **IN A DAY AT 8 AM** FOR 7 DAYS

REVIEW IN GENERAL MEDICINE OPD WITH FASTING BLOOD SUGAR AND POST PRANDIAL BLOOD GLUCOSE LEVELS AFTER 7 DAYS ALONG WITH RP -2

ARH1.0001232528

**Patient Identifier** ARHIP56329

**Sex** Male

**Date of Discharge**  
**MLC No**

**Address** CHINNAKALVALA,SULTHANABAD,Karimnagar,Telangana

**Primary Consultant** DR. NIKHIL GOLI --NEUROLOGY

**Name** Mr. K  
CHANDRAIAH

**Age** 65Yr  
0Mth  
6Days

**Date of Admission** 24-Jun-2022

**Ward/Bed No** Second  
Floor,  
Male  
General Ward,  
Bed  
no:GW  
23

CVA - ACUTE ISCHAEMIC STROKE  
CAD

C/o left sided weakness, slurring of speech and deviation of mouth

Known case of hypertension

AT ADMISSION:

Afebrile

PR: 72/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 65 years old male patient CHANDRAIAH came with c/o left sided weakness, slurring of speech and deviation of mouth. All necessary investigations were done and diagnosed as CVA - ACUTE ISCHAEMIC STROKE, CAD. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 75 MG ONCE DAILY AT 2PM FOR 11 DAYS
2. TAB. CLOPITAB 75 MG ONCE DAILY AT 2PM FOR 11 DAYS
3. TAB. ATORVA 40 MG ONCE DAILY AT 8PM FOR 11 DAYS
4. TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

REVIEW AFTER 11 DAYS IN DR NIKHIL GOLI SIR OPD

ARH1.0001232666

**Name**

Mr.  
SRINIVAS  
CH

**Patient Identifier**

ARHIP56384

**Age**

57Yr  
0Mth  
3Days

**Sex**

Male

**Date of  
Admission**

27-Jun-  
2022

**Date of Discharge  
MLC No**

**Address**

7-1-243  
MANKAMATHOTHA, Karimnagar, Telang  
ana

**Ward/  
Bed No**

First  
Floor,  
SICU,  
Bed  
no: SICU  
2

**Primary Consultant**

DR. SUBRAT KUMAR SOREN

RTA - TRAUMATIC BRAIN INJURY  
FRONTAL LOBE CONTUSIONS  
CHRONIC KIDNEY DISEASE  
ACUTE DELIRIUM TREMENS

Alleged to have sustained injury due to RTA 2 wheeler Vs 2  
wheeler on 27/06/2022 around 10.30 AM  
H/o LOC, Oral bleed+

Known case of HTN, T2DM

AT ADMISSION:

Patient c/c

PR: 87/min

BP: 160/110mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 90%



P/A: Soft, BS+

GCS- 15/15

A 57 years old male patient SRINIVAS came with alleged to have sustained injury due to RTA 2 wheeler Vs 2 wheeler on 27/06/2022 around 10.30 AM, h/o LOC, Oral bleed+. All necessary investigations were done and diagnosed as RTA - TRAUMATIC BRAIN INJURY, FRONTAL LOBE CONTUSIONS, CHRONIC KIDNEY DISEASE, ACUTE DELIRIUM TREMENS. **Managed conservatively.** Nephrology consultation was taken due to the raised Sr. Creatinine level and advice followed. Psychiatrist consultation was taken due to agitated behaviour of patient and advice followed. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB. BREVIPIL 50 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE
2. TAB. PAN 40MG ONCE DAILY AT 7AM (BBF) FOR 7 DAYS.
3. TAB. ANXOZAP (OXAZEPAM) 10 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS
4. TAB. QUITIAPIN 25 MG ONCE DAILY AT 8PM FOR 7 DAYS.
5. TAB. THIAMINE 10 MG ONCE DAILY AT 2PM FOR 7 DAYS.
6. TAB. SOBINIX 500 MG ONCE DAILY AT 2PM FOR 7 DAYS.
7. TAB. TELISTA AM ONCE DAILY AT 8AM FOR 7 DAYS.
8. TAB. GLUCORYL-MVS ONCE DAILY AT 8AM FOR 7 DAYS.

REVIEW AFTER 11 DAYS IN NEUROSURGERY OPD

ARH1.0001232750

**Name**

Mr. N RAVINDAR

**Patient Identifier**

ARHIP56416

**Age**

55Yr  
0Mth  
0Days

**Sex**

Male

**Date of Admission**

30-Jun-2022

**Date of Discharge  
MLC No**

**Address**

RAMANNAPET,Sircilla,Telangana

**Ward/  
Bed No**

First Floor,  
Day Care,  
Bed no:D C 6

**Primary Consultant**

Dr. KRISHNA CHAITANYA

CAG- MINOR CAD

C/o giddiness, vomitings since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 55 years old male patient Mr. RAVINDER presented with history of giddiness. CAG done showed minor CAD. His medications were optimised. Hence being discharged with the following medication.

DISCHARGE MEDICATION:

1. TAB. ROZUVAS 10 MG ONCE IN A DAY AT 9 P.M. TO CONTINUE

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001232583

**Name**

Mrs.  
CHINNA  
MALLAMMA  
KONDRA

**Patient Identifier**

ARHIP56340

**Age**

76Yr  
5Mth  
5Days

**Sex**

Female

**Date of  
Admission**

25-Jun-  
2022

**Date of Discharge  
MLC No**

**Address**

4-591,  
KODURUPAKA, PEDDAPALLI, Karimnagar, Telang  
ana

**Ward/  
Bed No**

First  
Floor,  
CICU ,  
Bed  
no: CICU  
4

**Primary Consultant**

Dr. KRISHNA CHAITANYA

VALVULAR HEART DISEASE  
SEVERE AORTIC REGURGITATION  
NO HF  
SR  
AORTIC ROOF ANGIOGRAM -SEVERE AORTIC REGURGITATION

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 76 years old female patient Mrs. CHINNA MALLAMMA KONDRA presented with complaint of dyspnoea giddiness on evaluation ECG showed a beginning echo showed moderate to severe aortic regurgitation CAG done which showed normal coronaries aortic roof angiogram showed severe aortic regurgitation. Patient was planned aortic valve replacement. Hence being discharged with the following medication.

DISCHARGE MEDICATION:

1. TAB. FRUSELAC-DS ½ TAB ONCE IN A DAY AT 8 AM TO CONTINUE
2. TAB. RAMISTAR 2.5 MG ONCE IN A DAY AT 8 AM TO CONTINUE

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001232640

**Name**

Mr. R  
ANJIAH

**Patient Identifier**

ARHIP56373

**Age**

50Yr  
8Mth  
5Days

**Sex**

Male

**Date of  
Admission**

27-Jun-  
2022

**Date of Discharge  
MLC No**

**Address**

1-29,KACHIREDDIPALLE,  
GANGADHARA,Karimnagar,Telanga  
na

**Ward/  
Bed No**

First  
Floor,  
CICU ,  
Bed  
no:CICU1  
3

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, NSTEMI

MILD LV SYSTOLIC DYSFUNCTION, SR

CORONARY ANGIOGRAM DONE ON 27/06/2022 – CAD-DVD (RCA, LCX)

PTCA+DES TO RCA, OM2 (2 STENTS) RCA WITH 3.0 X 33 MM XIENCE XPEDITION, OM2 WITH 2.75 X 18 MM XIENCE XPEDITION DONE ON 28/06/2022

C/o chest pain since 2 days associated with fever

AT ADMISSION:

PR: 80/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 50 years old male patient Mr. ANJALIAH came with c/o chest pain since 2 days associated with fever . All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, MILD LV SYSTOLIC DYSFUNCTION, SR , CORONARY ANGIOGRAM DONE ON 27/06/2022 - CAD-DVD (RCA, LCX), PTCA+DES TO RCA, OM2 (2 STENTS) RCA WITH 3.0 X 33 MM XIENCE XPEDITION, OM2 WITH 2.75 X 18 MM XIENCE XPEDITION DONE ON 28/06/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. AXCER 90MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. NOVASTAT 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. METOLAR XR 25MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

REVIEW AFTER 7 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.



ARH1.0001232492

**Name**

Mr.  
RAJESHAM  
VASAM

**Patient Identifier** ARHIP56315

**Age** 53Yr  
0Mth  
6Days

**Sex** Male

**Date of Admission** 24-Jun-2022

**Date of Discharge**  
**MLC No**

**Address** H.NO:1-  
38/1,MUNJAMPALLY,KARIMNAGAR,Karimnagar,Telangana

**Ward/Bed No** First Floor,  
CICU ,  
Bed no:CICU 3

**Primary Consultant** Dr. KRISHNA CHAITANYA M (

CAD AWSTEMI, MILD MODERATE LV DYSFUNCTION

CONTROLLED HF, SR

CARDIOGENIC SHOCK  
AKI ON CKD  
DIABETES MELLITUS

Complaint of chest pain and breathing difficulty

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 65/min

BP: 140/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 53 years old male patient Mr. RAJESHAM VASAM presented with complaint of chest pain and breathing difficulty, on evaluation. STEMI with aVR ST elevation suggestive LMCA or critical TVD. CAG done showed LMCA + TVD. He was stabilised . His renal parameters deranged secondary to cardiogenic shock. Diabetic nephropathy. He was stabilised with IV medication. Family were explained about high risk for CABG. In view of renal dysfunction. Risk for sudden cardiac arrest explained to family members. He is being discharged with following medication

#### DISCHARGE MEDICATION:

-----

1. TAB. AZTOR 10 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS
3. TAB. NIKORAN 5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. FLAVEDON MR 35MG **THRICE IN A DAY AT 8 AM 2PM 8 PM** TO CONTINUE.
5. TAB. RENOSAVE **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. KETO CHECK **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. MET-XL 50MG ONCE DAILY AT 8AM TO CONTINUE.
8. TAB. FRUSELAC ONCE DAILY AT 8AM TO CONTINUE.
9. TAB. VELTAM 0.2 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001232651

<b>Name</b>	Mrs. BHUMAKKA APPANI		
<b>Patient Identifier</b>	ARHIP56371	<b>Age</b>	70Yr 0Mth 4Days
<b>Sex</b>	Female	<b>Date of Admission</b>	27-Jun-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	NAMNOOR, HAZIPUR, MANCHERIAL,Tandur,Telangana	<b>Ward/ Bed No</b>	First Floor, CICU , Bed no:CICU10
<b>Primary Consultant</b>	Dr. KRISHNA CHAITANYA M (MD,DM,(FNB) INTERVENTIONAL CARDIOLOGIST)--CARDIOLOGY		

CORONARY ARTERY DISEASE, NSTEMI

MILD LV SYSTOLIC DYSFUNCTION, EF-45%, SR

CAG-DVD ON 28/06/2022

PTCA TO LAD, LCX [2 STENTS] LAD WITH XIENCE XPEDITION 2.75 X 33 MM, LCX WITH XIENCE XPEDITION 2.75 X 33 MM DONE ON 28/06/2022

C/o chest pain associated with SOB since 1 day

K/c/o Hypertension

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 80/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 70 years old woman Mrs. BHUMAKKA presented with complaint of chest pain on evaluation, diagnosed to have NSTEMI, mild LV dysfunction, SR, coronary angiogram done showed LAD and LCX regions. PTCA to LCX thrombotic total occlusion and LAD done. Good result. TIMI-III flow. She is symptomatically better and haemodynamically stable, hence being discharged with following advice.

#### DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG **TWICE IN A DAY AT 8 AM, 8 PM** TO CONTINUE.
3. TAB. ATORVA 40 MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. MET-XL 12.5 MG **TWICE IN A DAY AT 8 AM 8 PM**
5. TAB. IVABID 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. LASIX 40 MG ½ TAB ONCE DAILY AT 8 AM TO CONTINUE.
7. TAB. ALDACTONE 50 MG ONCE DAILY AT 2PM TO CONTINUE.
8. TAB. NITROCONTIN 2.6 MG **TWICE IN A DAY AT 8 AM 2 PM** TO CONTINUE.
9. TAB. NIKORAN 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
10. TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH CBC, RP-2 Reports



## GANGAMMA

ARH1.0001232499		<b>Name</b>	Mrs. GANGAMMA PALEPU
<b>Patient Identifier</b>	ARHIP56319	<b>Age</b>	55Yr 11Mth 7Days
<b>Sex</b>	Female	<b>Date of Admission</b>	24-Jun-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	2- 72/1,THIMMAPUR,JAGTIAL,Karimnagar,Telangana	<b>Ward/Bed No</b>	First Floor, CICU , Bed no:CICU12
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY		

COMPLETE HEART BLOCK  
CORONARY ARTERY DISEASE

MODERATE AR/MR/MILD TR/PAH

SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%

CORONARY ANGIOGRAM (24/06/2022) -PROXIMAL LAD MILD STENOSIS

TPI DONE ON 27/06/2022  
PPI DONE ON 27/06/2022 WITH MEDTRONIC [VVIR]

C/o chest pain radiating to back since 1 day

AT ADMISSION:

Afebrile

PR: 78/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 55years old female patient Mrs. GANGAMMA PALEPU came with c/o chest pain radiating to back since 1 day. All necessary investigations were done and diagnosed as COMPLETE HEART BLOCK, CORONARY ARTERY DISEASE, AWTMI, MODERATE AR/MR/MILD TR/PAH, SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%, CORONARY ANGIOGRAM (24/06/2022) -PROXIMAL LAD MILD STENOSIS, TPI DONE ON 27/06/2022, PPI DONE ON 27/06/2022 WITH MEDTRONIC [VVIR] . Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. TONACT 20 MG **ONCE IN A DAY AT 8 PM AFTER DINNER** FOR 7 DAYS
- 2) TAB. AUGMENTIN DUO 625MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS
- 3) TAB. CHYMORAL FORTE **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS
- 4) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS
- 5) TAB. BEPLEX FORTE ONCE DAILY AT 2PM FOR 10 DAYS
- 6) SYP. ASCORYL-D 10 ml **TWICE IN A DAY AT 8 AM 8 PM**
- 7) T-BACT OINTMENT FOR L/A

REVIEW AFTER 11 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.



ARH1.0001232761

<b>Name</b>	Mrs. RAJAMMA G		
<b>Patient Identifier</b>	ARHIP56419	<b>Age</b>	45Yr 0Mth 1Days
<b>Sex</b>	Female	<b>Date of Admission</b>	30-Jun- 2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	KATKUR, ,Karimnagar,Telangana	<b>Ward/ Bed No</b>	First Floor, RECOVERY ROOM, Bed no:RR 7
<b>Primary Consultant</b>	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)--GENERAL SURGERY		

ACUTE FISSURE IN ANO WITH  
SURGERY: EVA LORD'S DILATATION + LATERAL SPHINCTEROTOMY DONE ON 30/06/2022

C/o per rectum bleeding, mild constipation since 1 month

PHYSICAL EXAMINATION:

ON ADMISSION

-----

Pt c/c/c

afebrile

PR-82/min

BP-110/60mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

SPO2-100%

A 45 yrs old female patient RAJAMMA came with c/o per rectum bleeding, mild constipation since 1 month. All necessary investigations done and diagnosed as ACUTE FISSURE IN ANO, SURGERY: EVA LORD'S DILATATION + LATERAL SPHINCTEROTOMY DONE ON 30/06/2022. Findings: Posterior fissure with severe anal spasm, sentinel pile noted. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

#### Discharge Medication:

1. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
2. TAB: ND Q10 ONCE DAILY AT 2PM FOR 30 DAYS.
3. GLUTAVAUULT -V SACHETS ONCE DAILY AT 8AM WITH GLASS OF WATER FOR 15 DAYS.
4. SYP. LACTIFIBER 3 TSP ONCE IN A DAY AT 8 PM
5. XYLOCAINE JELLY EVERY 4<sup>th</sup> hrly
6. METROGYL-P OINTMENT L/A THRICE DAILY AT 8AM 2PM 8PM
7. SITZ BATH TWICE DAILY

Review after 7 days in General Surgery OPD.

ARH1.0001232403

**Name**

Mr. K RAMULU

**Patient Identifier**

ARHIP56274

**Age**

75Yr  
0Mth  
3Days

**Sex**

Male

**Date of Admission**

21-Jun-2022

**Expired Date**

24-Jun-2022

**MLC No**

**Address**

RAMNAGAR  
KARIMNAGAR, Karimnagar, Telangana

**Ward/Bed No**

First  
Floor,  
CICU ,  
Bed  
no: CICU  
1

**Primary Consultant  
Surgeons**

Dr. Vidya Sagar A--CARDIOLOGY

**Consultants  
Anesthesiologists**

Diagnosis

**Diagnosis**

Disease	Disease Type
ISCHEMIC CARDIO MYOPATHMY, VENTRICULAR TACHYCARDIA, ACUTE KIDNEY INJURY.	

C/o chest pain since 2 days

AT ADMISSION:

PR: 72/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 75 years old male patient <sup>RAMULU</sup> came with c/o chest pain since 2 days. All necessary investigations were done and diagnosed as ISCHEMIC CARDIO MYOPATHMY, VENTRICULAR TACHYCARDIA, ACUTE KIDNEY INJURY. Poor prognosis explained to the patient attendants, suddenly patient unconscious. INJ. Atropine and INJ. ADRENALINE given, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and inotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLS guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 10.36 PM on 24/06/2022.

**CAUSE OF DEATH**

-----  
SUDDEN CARDIORESPIRATORY ARREST SECONDARY TO ISCHEMIC CARDIO MYOPATHMY, VENTRICULAR TACHYCARDIA, ACUTE KIDNEY INJURY

ARH1.0001231920

**Name**

Mr.  
PARSHARAM  
KAVVAMPALLY

**Patient Identifier** ARHIP56304

**Age** 52Yr  
0Mth  
17Days

**Sex** Male

**Date of Admission** 23-Jun-2022

**Expired Date** 26-Jun-2022  
**MLC No**

**Address** GANNERVARAM,Karimnagar,Telangan  
na

**Ward/Bed No** First  
Floor,  
CICU ,  
Bed  
no:CICU  
7

**Primary Consultant** Dr. Vidya Sagar A--CARDIOLOGY

**Consultants**

**Surgeons** Dr. Vidya Sagar A--CARDIOLOGY

**Anesthesiologists**

☐ **Diagnosis**  
**S**

**Diagnosis**

Disease	Disease Type
LATE STENT THROMBOSIS,PTCA TO DOUBLE STENT TO LAD,ACUTE PULMONARY EDEMA,ACUTE RENAL FAILURE	

C/o chest pain a/w SOB since 1 day

**AT ADMISSION:**

PR: 20/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 52 years old male patient Mr. PARSHARAM KAVVAMPALLY came with c/o chest pain a/w SOB since 1 day. All necessary investigations were done and diagnosed as LATE STENT THROMBOSIS,PTCA TO DOUBLE STENT TO LAD,ACUTE PULMONARY EDEMA,ACUTE RENAL FAILURE. Poor prognosis explained to the patient attendants, suddenly patient

became unconscious. INJ. Atropine and INJ. ADRENALINE given, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and inotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 12.14 AM on 26/06/2022.

#### CAUSE OF DEATH

-----

SUDDEN CARDIOPULMONARY ARREST SECONDARY TO LATE STENT  
THROMBOSIS,PTCA TO DOUBLE STENT TO LAD,ACUTE PULMONARY EDEMA,ACUTE RENAL FAILURE

ARH1.0001144725

<b>Name</b>	Mrs. GUMMULA RAJAVVA		
<b>Patient Identifier</b>	ARHIP56368	<b>Age</b>	69Yr 7Mth 12Days
<b>Sex</b>	Female	<b>Date of Admission</b>	27-Jun-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	VELAGATOOR,Karimnagar,Telangana	<b>Ward/Bed No</b>	First Floor, CICU , Bed no:CICU 2
<b>Primary Consultant</b>	Dr. Vidya Sagar		

CORONARY ARTERY DISEASE, ACUTE AWM

MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%

AF ON CARDARONE INJECTION -->SR

CORONARY ANGIOGRAM DONE ON 27/06/2022 - CAD-SVD (LAD)

PRIMARY PTCA+DES TO LAD WITH 3.0 X 24 MM METAFOR DONE ON 27/06/2022  
ACUTE PULMONARY OEDEMA [RECOVERED]  
R/F: HTN

C/o chest pain since 1 day associated with vomitings

AT ADMISSION:

Afebrile

PR: 81/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 69 years old female patient Mrs. GUMMULA RAJAVVA came with c/o chest pain since 1 day associated with vomitings . All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%, AF ON CARDARONE INJECTION -->SR , CORONARY ANGIOGRAM DONE ON 27/06/2022 - CAD-SVD (LAD), PRIMARY PTCA+DES TO LAD WITH 3.0 X 24 MM METAFOR DONE ON 27/06/2022, ACUTE PULMONARY OEDEMA [RECOVERED]. Patient developed AF on 28/06/22 - reverted to SR on CORDARONE INJ. And another episode of atrial flutter developed on 02/07/22 on CORDARONE INJ. Reverted to SR, Acute pulmonary oedema [recovered]. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPITAB 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. ACITROM 1 MG ONCE DAILY AT 4PM TO CONTINUE.
- 4) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. CORDARONEX 200 MG ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. METOLAR XR 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 7) TAB. DYTOR PLUS ONCE DAILY AT 8AM TO CONTINUE.
- 8) TAB. PANTOCID 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH PT, INR, CBC

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER /  
EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW  
REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL  
CENTER AT- 0878-2200000.



ARH1.0001232806

<b>Name</b>	Mrs. NEELAM MUNEMMA		
<b>Patient Identifier</b>	ARHIP56443	<b>Age</b>	60Yr 0Mth 1Days
<b>Sex</b>	Female	<b>Date of Admission</b>	01-Jul-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	THIRUMALAPUR,Karimnagar,Telangana	<b>Ward/Bed No</b>	First Floor, MICU, Bed no:MICU 11
<b>Primary Consultant</b>	DR. NIKHIL GOLI --NEUROLOGY		

C/o shortness of breath grade-3 since few days, drowsiness+

AT ADMISSION:

Afebrile

PR: 80/min

BP: 130/870mmHg

RS: BAE+

CVS: S1S2

RR: 17/min

SPO2: 98%

P/A: Soft

A 60 years old female patient Mrs. NEELAM MUNEMMA came with c/o shortness of breath grade-3 since few days, drowsiness+. All necessary investigations were done and diagnosed as ACUTE KIDNEY INJURY WITH HPERKALEMIA. Managed conservatively. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA.

ARH1.0001232043

Name

Mrs. PREAMALATHA  
G

Patient Identifier

ARHIP56204

Age

69Yr 0Mth 19Days

Sex

Female

Date of

Admission

17-Jun-2022

Date of Discharge

28-Jun-2022

MLC No

Address

11-2-303 INDIRA  
NAGAR,Karimnagar,Telangana  
Dr SOMASHEKAR

Ward/Bed No

First Floor, CT  
POST, Bed no:CT 3

Primary Consultant

K(MS,MCH(CTVS),Consultant-  
Cardio Thoracic & Vascular  
Surgeon)--C T SURGERY

Consultants

Surgeons

Dr SOMASHEKAR  
K(MS,MCH(CTVS),Consultant-  
Cardio Thoracic & Vascular  
Surgeon)--C T SURGERY

Anesthesiologists

Dr. K.S.D.KRISHNA  
KIRAN--  
ANAESTHESIOLOGY

Diagnosis



S

Diagnosis

Disease

Disease Type

CORONARY ARTERY DISEASE +TRIPLE VESSEL DISEASE+LV DYSFUNCTION+HYPERTENSION+STATUS POST AAWMI

SURGERY -CORONARY ARTERY BYPASS GRAFTING [SVG TO LAD, OM, PDA]  
DONE ON 21/06/2022

C/o chest pain since 3 days

AT ADMISSION:

PR: 89/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 69 years old female patient Mrs. PREMALATHA came with c/o chest pain since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE +TRIPLE VESSEL DISEASE+LV DYSFUNCTION+HYPERTENSION+STATUS POST AAWMI, SURGERY -CORONARY ARTERY BYPASS GRAFTING [SVG TO LAD, OM, PDA] DONE ON 21/06/2022. Poor prognosis explained to the patient attendants, suddenly

patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and inotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 11.30 AM on 28/06/2022.

## CAUSE OF DEATH

-----

CARDIOPULMONARY ARREST SECONDARY TO SEPTIC SHOCK, LOW CARDIAC OUTPUT, LV DYSFUNCTION, K/C/O CAD, S/P CABG

ARH1.0001232744		Name	Ms. NAVAYASRI MAVURAM	
Patient Identifier	ARHIP56412	Age	28Yr 1Mth 22Days	
Sex	Female	Date of Admission	30-Jun-2022	
Date of Discharge				
MLC No				
Address	KMR,Karimnagar,Telanga na		Ward/Bed No	First Floor, SICU, Bed no:SICU 1
Primary Consultant	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)-- GENERAL SURGERY		Consultants	
Surgeons	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)-- GENERAL SURGERY		Anesthesiologists	Dr Subba Reddy Kuppannagari-- ANAESTHESIOLOGY

Diagnosis

Diagnosis

[Add  
Diagnosis](#)

ARHIP56412	ARH1.000123274
------------	----------------

☐ Surgery / Procedures  
Done

**Surgery / Procedure**

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
--------------------------	------------	----------	----------	--------------

LAPROSCOPIC CHOLECYSTECTOMY

ACUTE CALCULUS CHOLECYSTITIS WITH PASSED CBD CALCULUS  
SURGERY: LAPROSCOPIC CHOLECYSTECTOMY DONE ON 01.07.2022

C/o pain abdomen since 5 days

## PHYSICAL EXAMINATION:

### ON ADMISSION

-----

Pt c/c/c

afebrile

PR-82/min

BP-120/80mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 28 yrs old female patient Ms. NAVAYASRI MAVURAM came with c/o pain abdomen since 5 days. All necessary investigations done and diagnosed as ACUTE CALCULUS CHOLECYSTITIS WITH PASSED CBD CALCULUS, SURGERY: LAPROSCOPIC CHOLECYSTECTOMY DONE ON 01.07.2022. Findings: Well distended gallbladder with well defined calot's. Inflammatory changes noted with mild wall thickening. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. TAB: SOMPAZ-L TWICE DAILY AT 8AM, 8PM FOR 15 DAYS
5. TAB: VSL-3 ONCE DAILY AT 2PM FOR 15 DAYS.
6. GLUTAWAULT SACHETS ONCE DAILY AT 2PM FOR 15 DAYS.

Review after 7 days in General Surgery OPD.

ARH1.0001232806

**Name**

Mrs.  
NEELAM  
MUNEMMA

**Patient Identifier** ARHIP56443

**Age** 60Yr  
0Mth  
1Days

**Sex** Female

**Date of Admission** 01-Jul-2022

**Date of Discharge**  
**MLC No**

**Address** THIRUMALAPUR,Karimnagar,Telangana

**Ward/Bed No** First Floor, MICU, Bed no:MICU 11

**Primary Consultant Surgeons** DR. NIKHIL GOLI --NEUROLOGY

**Consultants**

ACUTE LEFT MCA INFARCT  
POST THROMBOLISATION WITH INJ. TENECTEPLASE

C/o sudden onset of slurring of speech since 11:30 a.m. on 01/07/22  
History of LOC +

AT ADMISSION:

Afebrile

PR: 90/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 60 years old female patient Mrs. NEELAM MUNEMMA came with c/o sudden onset of slurring of speech since 11:30 a.m. on 01/07/22, history of LOC +. All necessary investigations were done and diagnosed as ACUTE LEFT MCA INFARCT, POST THROMBOLISATION WITH INJ. TENECTEPLASE. Managed conservatively. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA. Patient not willing for CT-Scan to restart antiplatelets.



ARH1.0001099939

**Name**

Mrs. GADDI  
RENUKA

**Patient  
Identifier**

ARHIP56431

**Age**

36Yr  
4Mth  
12Days

**Sex**

Female

**Date of  
Admission**

01-Jul-  
2022

**Date of  
Discharge  
MLC No**

**Address**

THIMMAPUR,Karimnagar,Telangan  
a

**Ward/  
Bed No**

First  
Floor,  
SICU,  
Bed  
no:SICU  
3

**Primary  
Consultant**

Dr. GOUTHAM ROY

## ACUTE INTESTINAL OBSTRUCTION

C/o pain abdomen

H/o nausea with 2 episodes of vomiting

### AT ADMISSION:

Afebrile

PR: 80/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft

A 36 years old female patient Mrs. GADDI RENUKA came with c/o pain abdomen, h/o nausea with 2 episodes of vomiting. All necessary investigations were done and diagnosed as ACUTE INTESTINAL OBSTRUCTION. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

-----

- REVIEW AFTER 7 DAYS IN GENERAL SURGERY OPD

## Diagnosis

### Diagnosis

Disease	Disease Type
SEPSIS WITH AKI RIGHT EAR MALIGNANT AND MULTIPLE CRANIAL NERVE PALSY.	

C/o slurring of speech, altered sensorium,  
H/o fever, nausea, vomiting

K/c/o HTN, T2DM, Rt ear malignant

AT ADMISSION:

PR: 120/min

BP: 150/90 mmHg

CVS: S1S2

RR: 20/min

SPO2: 96% with 6 Litr O2

P/A: Soft, BS+

A 69 years old female patient Mrs. K NARSAMMA came with c/o slurring of speech, altered sensorium, h/o fever, nausea, vomiting. All necessary investigations were done and diagnosed as SEPSIS WITH AKI, RIGHT EAR MALIGNANT AND MULTIPLE CRANIAL NERVE PALSY. Poor prognosis explained to patient attendants. Patient had sinus bradycardia and decreased heart rate. Patient was intubated and connected to mechanical ventilator support on SIMV mode with fio2-100%. Patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 01.18 pm on 02/07/2022.

## CAUSE OF DEATH

-----

CARDIOPULMONARY ARREST SECONDARY TO SEPSIS WITH AKI  
RIGHT EAR MALIGNANT AND MULTIPLE CRANIAL NERVE PALSY.

APJ1.0001475650

**Name** Mrs.  
KOMAMARAMM  
A CH

**Patient Identifier** ARHIP56356

**Age** 70Yr  
1Mth  
27Days

**Sex** Female

**Date of Admission** 26-Jun-2022

**Date of Discharge**  
**MLC No**

**Address** 10-4-216,  
VAVILAPALLY,Karimnagar,Telanga  
na

**Ward/Bed No** First  
Floor,  
CICU ,  
Bed  
no:CICU  
8

**Primary Consultant** Dr. Vidya Sagar A--CARDIOLOGY

ACUTE DECOMPENSATED HEART FAILURE  
OLD HISTORY OF CORONARY ARTERY DISEASE, ACUTE ANTERIOR WALL MI,  
ACUTE PULMONARY OEDEMA  
SEVERE LV DYSFUNCTION, EF-30%. BRONCHIECTASIS, SEPSIS  
R/F DIABETES MELLITUS TYPE2

C/o Shortness of breath grade-3 since 2-3 days

ON ADMISSION VITAL

-----

Patient conscious, coherent

Afebrile

PR-85/min

BP-120/70mmhg

RR-19/min

RS-BAE+,

CVS-S1S2+

P/A-Soft, BS+

SPO2-98%

A 70 years old female patient Mrs. KOMAMARAMMA CH presented to with C/o Shortness of breath grade-3 since 2-3 days associated with a cough. All necessary investigations were done and diagnosed as ACUTE DECOMPENSATED HEART FAILURE, OLD HISTORY OF CORONARY ARTERY DISEASE, ACUTE ANTERIOR WALL MI, ACUTE PULMONARY OEDEMA, SEVERE LV DYSFUNCTION, EF-30%. BRONCHIECTASIS, SEPSIS R/F DIABETES MELLITUS TYPE2. Patient suddenly developed respiratory distress needing NIV and O2 support and managed conservatively. Pulmonologist consultation taken and advice followed. As patient is anaemic, Hb is 8.5, 1 unit PRBC blood transfusion done and Hb improved to 9.6 mg/dL. Patient's condition and the need for further hospitalisation explained to patient attendants but patient attendants requested for discharge hence, patient being discharged at request.

#### DISCHARGE MEDICATION:

-----

- 1) TAB.ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB.CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB.ATORVA 40MG ONCE DAILY AT 9PM TO CONTINUE.
- 4) TAB.DILZEM SR 90MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) INJ.HUMAN INSULATARD S/C 8 U TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 6) TAB.DYTOR PLUS 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 7) TAB.PANTOCID 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS
- 8) SYP.CREMAFFIN 10 ML ONCE DAILY AT 8PM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIOLOGY OPD WITH FBS, PLBS REPORTS.

56432

ARH1.000119767  
1

**Name**

Mr. K V  
HANUMANTH  
A RAO

**Patient  
Identifier**

ARHIP56432

**Age**

89Yr  
10Mth  
2Days

**Sex**

Male

**Date of  
Admission**

01-Jul-  
2022

**Date of  
Discharge  
MLC No**

**Address**

CRITAIN COLONY,  
KARIMNAGAR,Telangan  
a

**Ward/Bed No**

First  
Floor,  
MICU,  
Bed  
no:MIC  
U 6

**Primary  
Consultant**

Dr Chandra Shekar  
Sathineni(MD (Internal  
Medicine) )--INTERNAL  
MEDICINE

**Consultants**

**Surgeons**

**Anesthesiologi  
sts**

☐ **Diagnosis**

**Diagnosis**

Disease	Disease Type
---------	--------------

ACUTE CEREBELLAR HAEMORRHAGIC INFARCT.

C/o sudden onset of vomiting since 1 day  
known case of CVA, left hemiparesis

H/o Bilateral knee replacement 6 years back

AT ADMISSION:

Afebrile

PR: 83/min

BP: 190/110 mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 96%

P/A: Soft,

A 89 years old male patient HANUMANTHA RAO came with c/o sudden onset of vomiting since 1 day, known case of CVA, left hemiparesis, h/o Bilateral knee replacement 6 years back. All necessary investigations were done and diagnosed as ACUTE CEREBELLAR HAEMORRHAGIC INFARCT. Managed conservatively. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA. Referred to higher center for further management.

ARH1.000123  
2811

**Name**

Mrs.  
AJMERA  
NEELAB  
AI

**Patient Identifier** ARHIP56442

**Age**

58Yr  
1Mth  
3Days

**Sex** Female

**Date of Admission**

01-Jul-2022

**Date of Discharge** 03-Jul-2022

**MLC No**

**Address** 3-  
97,LAMBADITHANDA,GURJAL,BELLAMPALLE,M  
ANCHERIAL-8106466674,Telangana

**Ward/Bed No**

First  
Floor,  
CICU ,  
Bed  
no:CIC  
U4

**Primary Consultant Surgeon** Dr. Vidya Sagar A--CARDIOLOGY

**Consultants**

**Surgeons** Dr. Vidya Sagar A--CARDIOLOGY

**Anesthesiologists**

☐ **Diagnosis**  
S



## Diagnosis

Disease	Disease Type
CAD-NSTEMI,NORMSL LV SYSTOLIC FUNCTION (EF-60%)SR S/P;CAD-LM+TVD(LAD,LCX,RCA)DONE ON 02/07/2022 PLAN;CABG R/F;HYPERTENSION,TYPE2DM,TOBACCO(SNUFFING)	

CAD-NSTEMI,NORMSL LV SYSTOLIC FUNCTION (EF-60%)SR  
S/P;CAD-LM+TVD(LAD,LCX,RCA)DONE ON 02/07/2022  
PLAN;CABG  
R/F;HYPERTENSION,TYPE2DM,TOBACCO(SNUFFING)

C/o sudden onset chest pain a/w profuse sweating since 2 days

K/C/O Hypertension,TYPE2 DM,Tobacco(snuffing)

## At Admission

Afebrile

PR: 73/min

BP: 120/70 mmHg

RR-22/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-98%

A 58 years old female patient Mrs. AJMERA NEELABAI came with c/o sudden onset chest pain a/w profuse sweating since 2 days. All necessary investigations were done and

diagnosed as CAD-NSTEMI,NORMSL LV SYSTOLIC FUNCTION (EF-60%)SR, S/P;CAD-LM+TV D(LAD,LCX,RCA)DONE ON 02/07/2022, PLAN;CABG. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA. At the time of discharge PR-84 min, BP-120/60 mmHg, SPO2-97% on room air.

ARH1.0001232  
742

**Name**

Mrs.  
SAMMAKK  
A LINGALA

**Patient Identifier** ARHIP56411

**Age**

77Yr  
0Mth  
5Days

**Sex** Female

**Date of Admission**

30-Jun-2022

**Date of Discharge** 03-Jul-2022  
**MLC No**

**Address** H.NO:21-3-5,RADAGAMBALA  
BASTHI,BELLAMAPALLY,Mancherla,Telangan

**Ward/Bed No**

First  
Floor,  
CICU ,  
Bed  
no:CICU  
3

**Primary Consultant** Dr. Vidya Sagar A--CARDIOLOGY

**Consultants**

**Surgeons** Dr. Vidya Sagar A--CARDIOLOGY

**Anesthesiologists**

☐ **Diagnosis**  
S

**Diagnosis**

Disease	Disease Type
CAD-AWMI,MODERATE LV SYSTOLIC DYSFUNCTION(EF;35%)SR S/P;CAG DONE ON(01/07/202)CAD-LM+DVD(LAD,RCA) PLAN;CABG K/C/O-BRONCHIAL ASTHAMA,HTN	

C/o sudden onset chest pain a/w mild sweating, SOB since 1 day

K/c/o Hypertension,Bronchial asthma

At Admission

Afebrile

PR: 81/min

BP: 120/70 mmHg

RR-22/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-98%

A 77 years old female patient Mrs. SAMMAKKA LINGALA came with c/o sudden onset chest pain a/w mild sweating, SOB since 1 day. All necessary investigations were done and diagnosed as CAD-AWMI, MODERATE LV SYSTOLIC DYSFUNCTION(EF;35%)SR, S/P;CAG DONE ON(01/07/202)CAD-LM+DVD(LAD,RCA), PLAN;CABG, Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA. At the time of discharge PR-91 min, BP-110/70 mmHg, SPO2-98% on room air.

#### DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. BETALOC 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

5. TAB. RAMISTAR 1.25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS.

.0001232771

<b>Name</b>		Mrs. V RAJESHWARI	
<b>Patient Identifier</b>	ARHIP56420	<b>Age</b>	65Yr 0Mth 4Days
<b>Sex</b>	Female	<b>Date of Admission</b>	30-Jun-2022
<b>Date of Discharge</b>	03-Jul-2022		
<b>MLC No</b>			
<b>Address</b>	GODAVARIKHANI PEDDAPALLI ,Ramagundam,Telangana	<b>Ward/Bed No</b>	First Floor, CICU , Bed no:CICU 9
<b>Primary Consultant</b>	Dr. KRISHNA CHAITANYA M (MD,DM, (FNB) INTERVENTIONAL CARDIOLOGIST)-- CARDIOLOGY	<b>Consultants</b>	
<b>Surgeons</b>	Dr. KRISHNA CHAITANYA M (MD,DM, (FNB) INTERVENTIONAL CARDIOLOGIST)-- CARDIOLOGY	<b>Anesthesiologists</b>	
<b>Diagnosis</b>			
<div style="display: flex; justify-content: space-between; align-items: center;"> <div style="border: 1px solid black; padding: 5px;">Disease</div> <div style="border: 1px solid black; padding: 5px;">Disease Type</div> </div>			

CAD;UNSTABLE ANGINA,NORMAL LVFUNCTION,NO HF,SR  
CAG;LAD MID80%FOLLOWED BY DISTAL 70%STENOSIS  
PTCA TO LAD WITH 2.5X28MM XIENCE &2.25X15MM XIENCE (30/06/2022) GOOD RESULT.  
K/C/O-TYPE2DM

C/o chest pain on and off since 3 days

AT ADMISSION:

Afebrile

PR: 94/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 96%

P/A: Soft

A 65 years old female patient Mrs. V RAJESHWARI came with c/o chest pain on and off since 3 days. All necessary investigations were done and diagnosed as CAD;UNSTABLE ANGINA,NORMAL LVFUNCTION,NO HF,SR, CAG;LAD MID80%FOLLOWED BY DISTAL 70%STENOSIS, PTCA TO LAD WITH 2.5X28MM XIENCE &2.25X15MM XIENCE (30/06/2022) GOOD RESULT. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS
5. TAB. FLAVEDON MR 35MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. NIKORAN 5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. NITROCONTIN 2.6 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
8. SYP. LACTIFIBRE 15 ml ONCE DAILY AT 8PM TO CONTINUE.
9. TAB. INTAGLIP-M 50/500 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH CBC, RP2 REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER /  
EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW  
REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL  
CENTER AT- 0878-2200000.

ARH1.0001232813	<b>Name</b>	Ms. KAMALAMMA PERAMANDLA	
<b>Patient Identifier</b>	ARHIP56444	<b>Age</b>	62Yr 0Mth 3Days
<b>Sex</b>	Female	<b>Date of Admission</b>	01-Jul-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	Other,Other	<b>Ward/Bed No</b>	First Floor, MICU, Bed no:MICU 8
<b>Primary Consultant</b>	DR. NIKHIL GOLI -- NEUROLOGY		

## ACUTE INFARCT IN RIGHT MCA ASPIRATION PNEUMONIA

C/o sudden onset of left sided weakness, slurring of speech  
History of aphasia, altered sensorium

At Admission

PR: 100/min

BP: 90/60 mmHg

RR-18/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-98% with FIO2 80%

A 62 years old female patient Ms. KAMALAMMA PERAMANDLA came with c/o sudden onset of left sided weakness, slurring of speech, history of aphasia, altered sensorium . All necessary investigations were done and diagnosed as ACUTE INFARCT IN RIGHT MCA, ASPIRATION PNEUMONIA . Managed conservatively. On 03/07/2022 at 8.20 AM patient had bradycardia, CPR started Inj ADRENALINE, Inj. ATROPINE given, ROSC attained. Patient was intubated and connected to mechanical ventilator. Poor prognosis explained to patient attendants. Patient attendants requested for discharge hence patient being discharged under LAMA.



ARH1.0001232878	ARHIP56467	Mrs. M UMA   Female   40Yr 0Mth
-----------------	------------	---------------------------------

RTA TRAUMATIC BRAIN INJURY  
SMALL HAEMORRHAGIC CONTUSION LEFT BASIFRONTAL AND TEMPORAL LOBE  
THIN ACUTE SDH ALONG RIGHT PARIETAL CONVEXITY  
FRACTURE OCCIPITAL BONE, EXTENDING TO FORAMEN MAGNUM

Alleged h/o sustained injury due to RTA , 2 wheeler vs 4 wheeler  
on 03/07/2022 around 9.00 pm sustained injuries

H/o multiple episodes of vomiting+

AT ADMISSION:

Patient c/c/c

PR: 58/min

BP: 80/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft,

GCS- 15/15 Moving all 4 limbs equally

A 40 years old female patient **UMA** came with **alleged h/o sustained injury due to RTA 2 wheeler vs 4 wheeler on 03/07/2022 around 9.00 pm sustained injuries, multiple episodes of vomitings+**. All necessary investigations were done and diagnosed as RTA TRAUMATIC BRAIN INJURY, SMALL HAEMORRHAGIC CONTUSION LEFT BASIFRONTAL AND TEMPORAL LOBE, THIN ACUTE SDH ALONG RIGHT PARIETAL CONVEXITY, FRACTURE OCCIPITAL BONE, EXTENDING TO FORAMEN MAGNUM. **Managed conservatively.** Patient attendants requested for discharge, hence patient is being discharged at request.

**DISCHARGE MEDICATION:**

1. TAB. LEVIPIL 500 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS.
2. TAB: VERTIN 24 MG ONCE DAILY AT 2PM FOR 7 DAYS.
3. TAB. DOLO 650 TWICE DAILY AT 8AM, 8PM FOR 5DAYS.
4. SOFT CERVICAL COLLOR

**REVIEW AFTER 7 DAYS IN NEUROSURGERY OPD.**



ARH1.0001029397

ARHIP56468

Mr. M. PRASAD | Male | 48Yr 9Mth 8Days

RTA POLYTRAUMA

BURST FRACTURE D3 VERTEBRAL BODY WITH MILD RETROPULSION

FRACTURE D4, D5 POSTERIOR ASPECTS OF VERTEBRAL BODIES

FRACTURE POSTERIOR ASPECT OF RIGHT 4th, 5th RIBS AT COSTOVERTEBRAL JUNCTION

Alleged h/o sustained injury due to RTA 2 wheeler vs 4 wheeler  
on 03/07/22 around 9.00 pm sustained injuries

AT ADMISSION:

Patient c/c/c

PR: 89/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft,

GCS- E4,V5,M6, Moving all 4 limbs equally

A 48 years old male patient **PRASAD** came with **alleged h/o sustained injury due to RTA 2 wheeler vs 4 wheeler on 03/07/22 around 9.00 pm sustained injuries**. All necessary investigations were done and diagnosed as RTA POLYTRAUMA, BURST FRACTURE D3 VERTEBRAL BODY WITH MILD RETROPULSION, FRACTURE D4, D5 POSTERIOR ASPECTS OF VERTEBRAL BODIES, FRACTURE POSTERIOR ASPECT OF RIGHT 4th, 5th RIBS AT COSTOVERTEBRAL JUNCTION. **Managed conservatively**. Patient attendants requested for discharge to take higher center, hence patient is being discharged under LAMA.

ARH1.0001232593

**Name**

Mrs.  
MALLAVVA  
GADDAM

**Patient Identifier**

ARHIP56353

**Age**

61Yr  
0Mth  
9Days

**Sex**

Female

**Date of Admission**

26-Jun-2022

**Date of Discharge  
MLC No**

**Address**

3-54/1  
KONAPUR,Nizamabad,Telangana

**Ward/  
Bed No**

First  
Floor,  
CICU ,  
Bed  
no:CICU  
4

**Primary Consultant**

Dr. KRISHNA CHAITANYA M  
(MD,DM,(FNB)  
INTERVENTIONAL  
CARDIOLOGIST)--  
CARDIOLOGY

UNSTABLE ANGINA  
MINOR CAD  
VT/VF - DC CARDIOVERTED  
PERSISTENT HYPOCALCAEMIA, HYPOMAGNESAEMIA FOR EVALUATION  
NO H F  
SR

C/o Retrosternal chest pain, radiating to back since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 83/min

BP: 130/90 mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 61 years old female patient Mrs. MALLAVVA GADDAM presented with history of chest pain was diagnosed as NSTEMI and referred for further management. On evaluation patient had severe anaemia, persistent hyponatraemia, persistent hypokalaemia. She had an episode of VT/VF, successfully cardioverted. She was supplemented for hypokalemia, hypocalcemia, hyponatremia with TOLVAPTAN, IV KCL, IV Magnesium. She improved with medication. CAG done showed minor CAD. Her medications were optimised. She was discharged for further evaluation of suspected Siogrens with renal tubular acidosis with Nephrology and General Medicine as follow up.

DISCHARGE MEDICATION:

-----

1. TAB. SHELCAL-HD 1GM **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
2. TAB. ALDACTONE 50MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. MAGNORATE 1GM **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. LIVOGEN **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. FOLVITE 5MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD / SOS

ARH1.0001232821

**Name**

Mr.  
ANJANEYULU  
G

**Patient Identifier** ARHIP56447

**Age** 54Yr  
5Mth  
3Days

**Sex** Male

**Date of Admission** 01-Jul-2022

**Date of Discharge**  
**MLC No**

**Address** KMR,Karimnagar,Telangana

**Ward/ Bed No** First Floor, CICU , Bed no:CICU 7

**Primary Consultant** Dr. Vidya Sagar

CORONARY ARTERY DISEASE, ACUTE IWMI

MILD LV SYSTOLIC DYSFUNCTION, EF-45%

CORONARY ANGIOGRAM DONE ON 02/07/2022 – CAD-SVD (RCA)

PRIMARY PTCA+DES TO RCA WITH 3.5 X 37 MM METAFOR DONE ON 02/07/2022

C/o chest pain associated with SOB and profuse sweating since 1 day

S/P Hydrocele, hemorrhoidectomy 15 yrs back

AT ADMISSION:

Afebrile

PR: 69/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%



P/A: Soft

A 54 years old male patient Mr. ANJANEYULU came with c/o chest pain associated with SOB and profuse sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, MILD LV SYSTOLIC DYSFUNCTION, EF-45%, CORONARY ANGIOGRAM DONE ON 02/07/2022 - CAD-SVD (RCA), PRIMARY PTCA+DES TO RCA WITH 3.5 X 37 MM METAFOR [LOT NO: MG40, S/N :MTR35037] DONE ON 02/07/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. TONACT 80MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. PANTOCID 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS.

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001232816

**Name**

Mr.  
RANAGAI AH  
SANAGARAM

**Patient Identifier** ARHIP56446

**Age** 47Yr  
0Mth  
4Days

**Sex** Male

**Date of Admission** 01-Jul-2022

**Date of Discharge**  
**MLC No**

**Address** 6-42/1  
SULTANABAD, Karimnagar, Telangana

**Ward/ Bed No** First Floor, CICU , Bed no: CICU 1

**Primary Consultant** Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE AAWMI

MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%

CARDIAC ARREST [CPR DONE : 10 DC SHOCKS GIVEN]

S/P CAG (01/07/222) -CAD-SVD [LMCA]

PRIMARY PTCA+DES TO LAD WITH 3.5 X 33 MM METAFOR DONE ON 01/07/2022  
R/F: TOBACCO ADDICT, ALCOHOL, T2DM, HTN

C/o chest pain associated with SOB, sweating since 1 day

AT ADMISSION:

Afebrile

PR: 87/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 97%

P/A: Soft

A 47 years old male patient Mr. RANAGIAH SANAGARAM came with c/o chest pain associated with SOB, sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWM, MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%, CARDIAC ARREST [CPR DONE : 10 DC SHOCKS GIVEN], S/P CAG (01/07/222) -CAD-SVD [LMCA], PRIMARY PTCA+DES TO LAD WITH 3.5 X 33 MM METAFOR DONE ON 01/07/2022. Patient planned for CAG and PTCA, patient develop to 5 episodes of VT before PTCA and was given DC shock 150 J 5 times. He also developed further 5 episodes of VT during the procedure and DC shock 150 J, 5 times given. Reverted to normal sinus rhythm. Patient was intubated during the procedure. Post PTCA was uneventful. Patient is being discharged in haemodynamically stable condition.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. NOVOSTAT 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) INJ. INSULATARD 10 U S/C **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 5) TAB. PROLOMET R 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 6) TAB. DYTOR PLUS 10 MG ONCE DAILY AT 2PM TO CONTINUE.
- 7) TAB. PANTOCID 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH RP-2, FBS & PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER /  
EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW  
REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL  
CENTER AT- 0878-2200000.

ARH1.0001232952

**Name**

Mrs.  
GAJULA  
RAMADEVI

**Patient Identifier** ARHIP56498

**Age** 48Yr 0Mth  
0Days

**Sex** Female

**Date of Admission** 05-Jul-2022

**Date of Discharge**  
**MLC No**

**Address** SRT-226, 2INC BASTHI,  
BELLAMPALLI,,Mancheria, Telangana

**Ward/ Bed No** Ground  
Floor,  
Emergency Ward,  
Bed  
no:EME1

**Primary Consultant** Dr. KRISHNA CHAITANYA M  
(MD,DM)

CORONARY ARTERY DISEASE, UNSTABLE ANGINA

CORONARY ANGIOGRAM (05/07/2022) -NORMAL CORONARIES

PLAN MEDICAL MANAGEMENT

K/C/O HYPOTHYROIDISM

C/o chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 48 years old female patient Mrs. GAJULA RAMADEVI came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, CORONARY ANGIOGRAM (05/07/2022) -NORMAL CORONARIES , PLAN MEDICAL MANAGEMENT . Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. THYRONORM 50 MCG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001232901

**Patient Identifier** ARHIP56475

**Sex** Male

**Date of Discharge** 04-Jul-2022

**Name** Mr. CH  
BHOOMAIAH

**Age**

**Date of Admission**

80Yr  
0Mth  
2Days  
04-Jul-2022

**MLC No**

**Address**

RENDLA GUDA JANNARAM  
MANCHERIYAL, Adilabad(Adilabad), Telangana

**Ward/Bed No**

First  
Floor,  
Day  
Care,  
Bed  
no: D  
C 3

**Primary  
Consultant**

Dr. KRISHNA CHAITANYA M (MD,DM,(FNB)  
INTERVENTIONAL CARDIOLOGIST)--  
CARDIOLOGY

**Consultants**

**Surgeons**

Dr. KRISHNA CHAITANYA M (MD,DM,(FNB)  
INTERVENTIONAL CARDIOLOGIST)--  
CARDIOLOGY

**Anesthesiologists**

Diagnosis

**Diagnosis**

Disease

Disease Type

CORONARY ARTERY DISEASE CHEST PAIN FOR EVALUATION,  
CORONARY ANGIOGRAM DONE ON 4/07/2022,  
PLAN: MEDICAL MANAGEMENT.

H/o chest pain 1 month back

Unstable angina

ECG showed -T wave biphasic

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min



SPO2: 98%

P/A: Soft

A 80 years old male patient BHOOMAIAH came with h/o chest pain 1 month back, ECG showed -T wave biphasic. Day Care angiogram done for risk stratification, CAG showed- Minor CAD, Plan medical management. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN AV 75/10 MG ONCE DAILY AT 8PM TO CONTINUE.
2. TAB. NIKORAN 5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. FLAVEDAN MR 35MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

REVIEW AFTER 3 MONTHS / SOS TO CARDIAC OPD

56490

ARH1.00012305  
47

**Name**

Mr.  
SATHIAIA  
H BURRA

**Patient  
Identifier**

ARHIP56490

**Age**

69Yr  
2Mth  
2Days

**Sex**

Male

**Date of  
Admission**

05-Jul-  
2022

**Expired  
Date**

06-Jul-2022

**MLC No**

**Address**

TANGALLAPALLY,  
KOHEDA,,Siddipet,Telangana

**Ward/Bed No**

First  
Floor,  
MICU,  
Bed  
no:MIC  
U 9

**Primary  
Consultant**

Dr. RAMCHANDER  
TORREM(DM(NEPHROLOGY)  
(NIMS),RENAL TRANSPLANT  
PHYSICIAN)--NEPHROLOGY

**Consultants**

**Surgeons**

**Anesthesiologists**

☐ **Diagnosis**

**Diagnosis**

Disease	Disease Type
.	

SEPSIS WITH AKI  
K/C/O CAD IWMI,CVA

C/o sudden SOB since 1 day

AT ADMISSION:

PR: 96/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 93% with Fio2

P/A: Soft

A 69 years old male patient Mr. SATHIAIAH BURRA came with c/o sudden SOB since 1 day. All necessary investigations were done and diagnosed as SEPSIS WITH AKI, K/C/O CAD I/WMI,CVA. Poor prognosis explained to patient attendants, he may require mechanical ventilation. But patient attendants not willing for ventilator support. On 06/07/2022 at 1.40 AM patient developed bradycardia, CPR started according to ACLS guidelines, Patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 01.47 AM on 06/07/2022.

CAUSE OF DEATH

-----

CARDIOPULMONARY ARREST SECONDARY TO SEPSIS WITH AKI, K/C/O CAD I/WMI,CVA.

56494

ARH1.0001232940		<b>Name</b>	Mr. SRINIVAS POODARI
<b>Patient Identifier</b>	ARHIP56494	<b>Age</b>	54Yr 0Mth 1Days
<b>Sex</b>	Male	<b>Date of Admission</b>	05-Jul-2022
<b>Date of Discharge MLC No</b>			
<b>Address</b>	Other,Other	<b>Ward/ Bed No</b>	First Floor, MICU, Bed no:MIC U 3
<b>Primary Consultant</b>	DR. SANJAY KUMAR KAMINWAR		

CVA WITH ACUTE PONS BLEED

C/o weakness of left upper limb and lower limb  
H/o loss of speech on deviation of mouth to right side

AT ADMISSION:

PR: 116/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100% on room air

P/A: Soft

A 54 years old male patient Mr. P SRINIVAS came with c/o weakness of left upper limb and lower limb, h/o loss of speech on deviation of mouth to right side. All necessary investigations were done and diagnosed as CVA WITH ACUTE PONS BLEED.

Managed conservatively. Poor prognosis explained to patient attendants, On 06/07/2022 at 12.10 PM patient developed bradycardia, CPR started according to ACLS guidelines, Patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 12.27 PM on 06/07/2022.

#### CAUSE OF DEATH

-----

CARDIOPULMONARY ARREST SECONDARY TO CVA WITH ACUTE PONS BLEED

ARH1.0001232919

**Name**

Mrs. B  
SHANTHA

**Patient  
Identifier**

ARHIP56472

**Age**

50Yr  
0Mth  
3Days

**Sex**

Female

**Date of  
Admission**

04-Jul-  
2022

**Date of  
Discharge**

**MLC No**

**Address**

Sulthanabad,Karimnagar,Telanga  
na

**Ward/  
Bed No**

First  
Floor,  
MICU,  
Bed  
no:MIC  
U 7

**Primary  
Consultant**

DR. SRI KARAN UDDESH

NSIP [NON-SPECIFIC INTERSTITIAL PNEUMONIA]

C/o Shortness of breath, cough since 15 days

AT ADMISSION:

Patient c/c

PR: 120/min

BP: 100/60 mmHg

RS: Bilateral diffuse Velcro crackles, Tachypnoeic

CVS: S1S2

RR: 30/min

SPO2: 92% with 10 Litr of O2 NRBS

P/A: Soft

A 50 years old female patient Mrs. B SHANTHA came with above mentioned complaints. Patient was tachypnoeic in ER was put on NRBM mask at 10 L/min was maintaining saturation at 92%. CT chest revealed non-specific interstitial pneumonia involving bilateral lungs to about 70%-80%. Patient was started on glucocorticoids and broad spectrum antibiotics. Patient developed severe respiratory distress and patient was intubated in view of severe respiratory distress. Now the patient is on mechanical ventilator and needs further treatment, but the attenders are unwilling, hence patient is being discharged against medical advice.

ARH1.0001232944

<b>Name</b>	Mr. N BHADRAIAH
<b>Patient Identifier</b>	ARHIP56493
<b>Age</b>	65Yr 0Mth 2Days
<b>Sex</b>	Male
<b>Date of Admission</b>	05-Jul-2022
<b>Date of Discharge</b>	
<b>MLC No</b>	
<b>Address</b>	CHINTAKUNTA,Karimnagar,Telangana
<b>Ward/ Bed No</b>	First Floor, MICU, Bed no:MICU 5
<b>Primary Consultant</b>	Dr Chandra Shekar Sathineni(MD (Internal

## ACUTE EXACERBATION OF COPD COR-PULMONALE

C/o shortness of breath grade 4 since 7 days associated with fever, cough with sputum

AT ADMISSION:

PR: 91/min

BP: 140/110 mmHg

RS: BAE+

CVS: S1S2

RR: 21/min

SPO2: 95% on room air

P/A: Soft



A 65 years old male patient BHADRAIAH came with c/o shortness of breath grade 4 since 7 days associated with fever, cough with sputum. All necessary investigations were done and diagnosed as **ACUTE EXACERBATION OF COPD, COR-PULMONALE**. Managed conservatively. Patient attendants requested for discharge, hence patient is being discharge at request.

DISCHARGE MEDICATION:

-----

- 1) TAB. FPM-ACT 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 2) TAB. LINOZEM 600 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 3) TAB. PULMOCLEAR TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 4) TAB. BILAHENZ-M ONCE DAILY AT 8PM FOR 10 DAYS
- 5) TAB. PIDOTIMMUNE 800 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 6) TAB. HEADNEURON ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 5 DAYS IN GENERAL MEDICINE OPD

ARH1.0001232809

<b>Name</b>	Ms. T KANAKALAXMI		
<b>Patient Identifier</b>	ARHIP56440	<b>Age</b>	74Yr 0Mth 6Days
<b>Sex</b>	Female	<b>Date of Admission</b>	01-Jul-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	ADARSH NAGAR KARIMNAGAR, Karimnagar, Telangana	<b>Ward/ Bed No</b>	First Floor, MICU, Bed no: MICU 2
<b>Primary Consultant</b>	DR. SRI KARAN UDDESH --INTERNAL		

ACUTE HEART FAILURE  
TO RULE OUT OSA

Shortness of breath since 1 week aggravated since 1 day

Known case of severe MI stenosis, diabetic mellitus, hypertension, osteoarthritis, cervical spondylosis

AT ADMISSION:

Afebrile

PR: 84/min

BP: 130/80mmHg

RS: b/l wheeze+

CVS: S1S2

RR: 24/min

SPO2: 96% wirh 2 Litr O2

P/A: Soft

A 74 years old female patient KANAKALAXMI came with above mentioned complaints. Patient was diagnosed with heart failure, patient was treated with diuretics and patient also had probable OSA component. Patient was treated with nebulisation and INJ. HYDROCORT. In view of hypercapnic respiratory failure. The patient was treated with INJ. CEFTAZIDIME TAZOBACTAM for suspected community acquired pneumonia. Now the patient is symptomatically better hence being discharged with following advice.

DISCHARGE MEDICATION:

-----

1. TAB. DYTOR 10 MG 1 TAB AT 8AM & ½ TAB AT 2 PM FOR 7 DAYS
2. TAB. PAN 40 MG ONCE IN A DAY AT 7 AM BEFORE BREAKFAST FOR 7 DAYS
3. INJ. HUMAN ACTRAPID 15 UNITS AT 8 AM BEFORE BREAKFAST , 15 UNITS AT 2 PM BEFORE LUNCH AND 15 UNITS AT 8 PM BEFORE DINNER TO CONTINUE
4. INJ. LANTUS 15 UNITS AT 10 PM AFTER DINNER TO CONTINUE
5. TAB. PREGABALIN 75 MG ONCE IN A DAY TO 8 PM FOR 7 DAYS
6. SYP. ASCORIL-D 10ML THRICE DAILY

REVIEW AFTER 1 WEEK WITH FBS, PLBS REPORTS IN GENERAL MEDICINE OPD  
CPAP AT NIGHT FOR 4 HOURS

ARH1.0001229437		<b>Name</b>	Mr. LAXMAN BHAI RAJANBHAI RAO
<b>Patient Identifier</b>	ARHIP56407	<b>Age</b>	65Yr 10Mth 11Days
<b>Sex</b>	Male	<b>Date of Admission</b>	29-Jun-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	B/H, RAJASTHAN COLONY, KARODIA BAJWA ROAD, ,Vadodara,Gujarat	<b>Ward/Bed No</b>	First Floor, MICU, Bed no:MICU 6
<b>Primary Consultant</b>	DR. SRI KARAN UDDESH		

ACUTE CVA WITH SEPTIC SHOCK  
AKI

H/o persistant giddiness  
H/o multiple episodes of vomitings

Known case of type II diabetic mellitus

AT ADMISSION:

Afebrile

PR: 74/min

BP: 170/90mmHg

RS: b/l air entry+

CVS: S1S2

RR: 20/min

SPO2: 99% on room air

P/A: Soft

A 65 years old male patient Mr. LAXMAN BHAI RAJANBHAI RAO came with above mentioned complaints, initially patient had vomiting and giddiness so an MRI brain was ordered, MRI brain revealed bilateral mastoiditis, so an ENT consultation was taken ENT opined that it was CSOM with mastoiditis. So patient waned on the third day of hospitalisation patient developed severe ataxia altered sensorium and difficulty in swallowing, a repeat MRI brain revealed Acute infarcts in right MCA territory, right corona radiata and centrum semiovale. Neurologist consultation was taken and his advice was followed. Throughout the course of hospitalisation the patient's clinical status deteriorated. Now the patient is on mechanical ventilator, needs further treatment, But the attendants are unwilling, hence patient is being discharged against medical advice.

ARH1.0001169766

<b>Name</b>		Mr. P J PRABHAKAR	
<b>Patient Identifier</b>	ARHIP56491	<b>Age</b>	89Yr 5Mth 25Days
<b>Sex</b>	Male	<b>Date of Admission</b>	05-Jul-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	SITARAMPUR BANK COLONY KARIMNAGAR,Karimnagar,Telangana	<b>Ward/ Bed No</b>	First Floor, CICU , Bed no:CICU 8
<b>Primary Consultant</b>	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE AWM I  
MODERATE LV SYSTOLIC DYSFUNCTION [EF-40%]  
R/F : HTN, T2DM, BRONCHIAL ASTHMA  
PLAN MEDICAL MANAGEMENT

C/o Retrosternal chest pain since 12 AM on 04/07/2022

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96% on room air

P/A: Soft

A 89 years old male patient PRABHAKAR came with c/o retrosternal chest pain since 12 AM on 04/07/2022. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWWMI

MODERATE LV SYSTOLIC DYSFUNCTION [EF-40%]. Patient was advised for angiogram but in view of age and improvement by medication family members accepted for medical management. Patient was improved with antiplatelets, antianginal, antihypertensive medication. By the advice of the family members patient was discharged with medical management.

DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. LN BLOC **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. NATRILIX-SR 1.5MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. CONCOR COR 1.25 MG ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. GLYCORYL M1 ONCE DAILY AT 8AM TO CONTINUE.
8. TAB. DYNAPRES 0.2 MG ONCE DAILY AT 8AM TO CONTINUE.
9. TAB. SOBINIX 500 MG ONCE DAILY AT 8PM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

**Patient Identifier** ARHIP56327

**Age** 20Yr  
0Mth  
14Days

**Sex** Male

**Date of Admission** 24-Jun-2022

**Date of Discharge** 25-Jun-2022  
**MLC No**

**Address** RAMNAGAR  
MANCHRIAL ,Nirmal,Telangana

**Ward/Bed No** First Floor,  
SICU,  
Bed no:SICU 3

**Primary Consultant** DR. SUBRAT KUMAR  
SOREN --NEUROSURGERY

**Consultants**  
**Anesthesiologists**

**Surgeons**

Diagnosis

**Diagnosis**

Disease	Disease Type
ROAD TRAFFIC ACCIDENT WITH HEAD INJURY MINIMAL PNEUMOCEPHALUS FRONTAL LOBE CONTUSION.	

Alleged to have sustained injury due to RTA 2 wheeler vs 4 wheeler on 24/06/22 sustained injuries

AT ADMISSION:

Patient drowsy

Febrile -100 F

PR: 83/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%



P/A: Soft, BS+

GCS- E2,V3,M5, B/I PERL

A 59 years old female patient LAXMI REDDY came with Alleged to have sustained injury due to RTA Rolling of Car over the road on 26/05/22 around 3.30 pm sustained injury to right arm. All necessary investigations were done and diagnosed as RTA POLYTRAUMA, MULTIPLE SMALL HAEMORRHAGIC CONTUSIONS, TRAUMATIC SAH, DIFFUSE AXONAL INJURY GRADE-I, FRACTURE RIGHT HUMERUS. Patient was hypotensive, ionotropic support given and now patient is haemodynamically stable. Patient's Hb was 7.7 mg/dl and 1 unit PRBC transfusion given. Patient's condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA.

ARH1.0001232446

**Name**

Mr. M  
RAJANNA

**Patient Identifier**

ARHIP56397

**Age**

58Yr  
0Mth  
15Days

**Sex**

Male

**Date of  
Admission**

29-Jun-  
2022

**Date of Discharge  
MLC No**

**Address**

MALLIAL  
JAGITAL ,Karimnagar,Telangana

**Ward/  
Bed No**

First  
Floor,  
CT  
POST,  
Bed  
no:CT  
4

**Primary Consultant**

Dr SOMASHEKAR  
K(MS,MCH(CTVS),Consultant-Cardio  
Thoracic & Vascular Surgeon)--C T  
SURGERY

CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + S/P IWMI, CVA  
SURGERY - CORONARY ARTERY BYPASS GRAFTING [SVG TO OM, PDA] DONE  
ON 02/07/2022.

C/o retrosternal chest pain a/w sweating since 1 day

ON ADMISSION VITAL

-----

Patient conscious, coherent

Afebrile

PR-80/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 58 years old male patient Mr. RAJANNA presented to hospital with c/o retrosternal chest pain a/w sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + S/P IWMI, SURGERY - CORONARY ARTERY BYPASS GRAFTING [SVG TO OM, PDA] DONE ON 02/07/2022. Post operative period was uneventful. Neurophysician consolidation taken in view of CVA, acute infarcts and advice followed. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, PARADOXICAL SEPTAL MOTION, MILD LV DYSFUNCTION, NO PE/CLOT/VEG, EF-50%

BMI is \_\_\_\_\_ kg/m<sup>2</sup>.

Sr. Creatinine report on 03.07.2022 1.3 mg/dl.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. ND-VIT ONCE DAILY AT 2PM TO CONTINUE.
- 4) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. PROLOMET XL 12.5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 6) TAB. MET XL 12.5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 7) TAB. STROCIT 500 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 8) TAB. ENCORATE 500 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 9) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.
- 10) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.
- 11) TAB. TRAMADOL 50 MG THRICE DAILY AT 8AM 2PM 8PM FOR 5 DAYS

REVIEW AFTER 11 DAYS TO CTVS OPD



ARH1.0001232934

**Name**

Mr.  
LAXMIRAJAM  
SANDAVENI

**Patient Identifier**

ARHIP56492

**Age**

50Yr  
0Mth  
3Days

**Sex**

Male

**Date of  
Admission**

05-Jul-  
2022

**Date of Discharge  
MLC No**

**Address**

KARIMNAGAR,Karimnagar,Telang  
ana

**Ward/Bed  
No**

Second  
Floor,  
Male  
Genera  
l Ward,  
Bed  
no:GW  
13

**Primary Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE AWM I

SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%

R/F: HTN, DM

CORONARY ANGIOGRAM DONE ON 05/07/2022 - CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.0 X 18 MM PRONOVA CC DONE ON 05/07/2022

C/o sudden retrosternal chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 86/min

BP: 100/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 50years old male patient Mr. LAXMIRAJAM SANDAVENI came with c/o sudden retrosternal chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AAWMI, SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%, R/F: HTN, DM, CORONARY ANGIOGRAM DONE ON 05/07/2022 - CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.0 X 18 MM PRONOVA CC DONE ON 05/07/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. CILODOC 50MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 4) TAB. STORVAS 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS
- 6) TAB. INJ. HUMAN MIXTARD 30/70 24 UNITS AT 8AM AND 12 UNITS AT 8PM TO CONTINUE.
- 7) CAP. METOLAR XR 25MG **ONCE IN A DAY AT 8 AM** TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001232756

	<b>Name</b>	Mrs. MANNEMMA MOLAKULA		
<b>Patient Identifier</b>	ARHIP56423	<b>Age</b>	49Yr 5Mth 8Days	
<b>Sex</b>	Female	<b>Date of Admission</b>	30-Jun-2022	
<b>Date of Discharge</b>				
<b>MLC No</b>				
<b>Address</b>	8-44, CHINNAKODUR,Siddipet,Telangana	<b>Ward/ Bed No</b>	Second Floor, Female General Ward, Bed no:GW 2	
<b>Primary Consultant</b>	Dr. SURESH GOUD S(MS,M.Ch Urology(SVIMS),Consultant Urologist)--UROLOGY			

RIGHT RENAL CALCULUS  
SURGERY: RIGHT PCNL+DJ STENTING DONE ON 04.07.2022

C/o Right loin pain, burning micturition since 10 days

#### AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

All required investigations done and enclosed



A 49 yrs old female patient Mrs. MANNEMMA MOLAKULA came to the hospital with c/o right loin pain, burning micturition since 10 days. All necessary investigations done and diagnosed as RIGHT RENAL CALCULUS, RIGHT PCNL+DJ STENTING DONE ON 04.07.2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice. Patient explained for stent removal after 3 weeks.

#### DISCHARGE MEDICATION:

-----

1. TAB: CIFRAN 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: FAMOCID 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: NDQ10 ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO UROLOGY OPD, STENT REMOVAL AFTER 3 WEEKS

ARH1.0001233003		<b>Name</b>	Mr. K VENKAT NARSAIAH
<b>Patient Identifier</b>	ARHIP56505	<b>Age</b>	83Yr 0Mth 2Days
<b>Sex</b>	Male	<b>Date of Admission</b>	06-Jul-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	NEELOZIPALLI BOINPALLI,Karimnagar,Telangana	<b>Ward/ Bed No</b>	First Floor, MICU, Bed no:MIC U 3
<b>Primary Consultant</b>	DR. SRI KARAN UDDESH --INTERNAL MEDICINE		

ACUTE HEART FAILURE  
D5 WEDGE COMPRESSION FRACTURE

C/o low backache, facial puffiness and shortness of breath

Known case of bronchial asthma

AT ADMISSION:

Afebrile

PR: 87/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 93% on 2 L of O2

P/A: Soft,

A 83 years old male patient Mr. K VENKAT NARSAIAH came with above mentioned. Patient was diagnosed to have acute heart failure and was treated with IV diuretics. 2D echo was done and Cardiologist consultation was taken. In view of low back pain MRI spine was done which revealed D5 wedge compression fracture, neurosurgeon opinion was taken and neurosurgeon advised conservative management. Now the patient is requires 1 Litr/min oxygen support and has hence been advised further hospital stay, but the attenders are unwilling, hence he is being discharged against medical advice.

ARH1.0001232928

**Name**

Mr.  
SRINIVAS  
BABU N

**Patient Identifier**

ARHIP56477

**Age**

51Yr  
0Mth  
4Days

**Sex**

Male

**Date of  
Admission**

04-Jul-  
2022

**Date of Discharge  
MLC No**

**Address**

HUSNABAD,Husnabad,Telangana

**Ward/  
Bed No**

Second  
Floor,  
Semi  
Private,  
Bed  
no:101  
B

**Primary Consultant**

Dr. RAMCHANDER  
TORREM(DM(NEPHROLOGY

CKD STAGE-V

MVP WITH SEVERE MR [ECCENTRIC JET], MILD PAH

NORMAL LV FUNCTION, RVSP-30 mmHg

HTN, DM

C/o Shortness of breath associated with b/l pedal edema

Known case of HTN, T2DM, CKD

AT ADMISSION:

PR: 112/min

BP: 170/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft,

A 51 years old male patient Mr. SRINIVAS BABU N came with c/o shortness of breath associated with b/l pedal edema . All necessary investigations were done and diagnosed as CKD STAGE-V, MVP WITH SEVERE MR [ECCENTRIC JET], MILD PAH, NORMAL LV FUNCTION, RVSP-30 mmHg, HTN, DM. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise. 3 cycles of dialysis completed.

DISCHARGE MEDICATION:

-----

1. TAB. FAROALFA 200 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
2. TAB. METOZ 10 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. DYROR 20 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. CILACAR M 10/50 **ONCE IN A DAY AT 2 PM** TO CONTINUE.
5. TAB. GEROZ -LP THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS
6. TAB. ECOSPRIN 75 MG ONCE DAILY AT 2PM TO CONTINUE.
7. TAB. THYRONORM 25 MCG ONCE DAILY AT 7AM BBF TO CONTINUE.
8. TAB. MULTI-8 ONCE DAILY AT 2PM TO CONTINUE.
9. TAB. CARNIK-LC **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
10. TAB. UBILIFE ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 5 DAYS IN NEPHROLOGY OPD

ARH1.0001232805	<b>Name</b>	Mr. DEVAIAH M	
<b>Patient Identifier</b>	ARHIP56483	<b>Age</b>	72Yr 9Mth 7Days
<b>Sex</b>	Male	<b>Date of Admission</b>	04-Jul-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			

<b>Address</b>	6-6-1064,SHIVAJI NAGAR,Karimnagar,Telanga na	<b>Ward/Bed No</b>	Second Floor, Semi Private, Bed no:106 A
<b>Primary Consultant</b>	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)-- GENERAL SURGERY	<b>Consultants</b>	
<b>Surgeons</b>	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)-- GENERAL SURGERY	<b>Anesthesiologists</b>	Dr Subba Reddy Kuppannagari-- ANAESTHESIOLOGY

Diagnosis

Diagnosis

Add  
Diagnosis

ARHIP56483	ARH1.000123280
------------	----------------

Surgery / Procedures Done

Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
HERNIA (INGUINAL) WITH MESH				

RIGHT INGUINAL INDIRECT HERNIA  
SURGERY: RIGHT INGUINAL HERNIOPLASTY DONE ON 06/07/2022

C/o swelling in right inguinal region since 1 month

PHYSICAL EXAMINATION:

ON ADMISSION

-----

Pt c/c/c

afebrile

PR-86/min

BP-110/70mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

SPO2-98%

A 72 yrs old male patient Mr. DEVAIAH came with c/o swelling in right inguinal region since 1 month. All necessary investigations done and diagnosed as RIGHT INGUINAL INDIRECT HERNIA, SURGERY: RIGHT INGUINAL HERNIOPLASTY DONE ON 06/07/2022. Findings: 2 cm above inguinal ligament, Indirect defect noted. Post

operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

#### Discharge Medication:

1. TAB: ROXSAFE 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. GLUTAVULT SACHETS ONCE DAILY AT 8AM WITH GLASS OF WATER FOR 15 DAYS.
5. TAB: STAMLO 5 MG ONCE DAILY AT 8AM FOR 10 DAYS.

Review after 10 days in General Surgery OPD.

ARH1.0001231527	<b>Name</b>	Mr. SUDHEER KALLEPALLY	
<b>Patient Identifier</b>	ARHIP56454	<b>Age</b>	40Yr 1Mth 8Days
<b>Sex</b>	Male	<b>Date of Admission</b>	02-Jul-2022
<b>Date of Discharge</b>	04-Jul-2022		
<b>MLC No</b>			
<b>Address</b>	1-84,paddapalli,karimnagr,Karimnagar,Telangana	<b>Ward/Bed No</b>	Second Floor, Semi Private, Bed no:118C
<b>Primary Consultant</b>	Dr. RAMCHANDER TORREM(DM(NEPHROLOGY)(NIMS),RENAL TRANSPLANT PHYSICIAN)--NEPHROLOGY	<b>Consultants</b>	
<b>Surgeons</b>		<b>Anesthesiologists</b>	

☐ **Diagnosis**

**Diagnosis**

<b>Disease</b>	<b>Disease Type</b>
----------------	---------------------

ACUTE ON CHRONIC KIDNEY DISEASE -DN  
RENAL ANEMIA  
DIABETES MELLITUS  
HYPERTENSION

C/o facial puffiness, fever and cough since 3 days

Known case of HTN, T2DM

AT ADMISSION:

PR: 82/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft,

A 40 years old male patient Mr. SUDHEER KALLEPALLY came with c/o facial puffiness, fever and cough since 3 days . All necessary investigations were done and diagnosed as ACUTE ON CHRONIC KIDNEY DISEASE -DN

RENAL ANEMIA, DIABETES MELLITUS, HYPERTENSION. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

1. TAB. SOBINIX DS **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
2. TAB. CARDIVAS 12.5 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. MOXIVAS 3.5 MG THRICE DAILY AT 8AM, 2PM & 8PM TO CONTINUE.
4. TAB. GEROZ -LP THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS
5. TAB. PAN 40 MG ONCE DAILY AT 8AM FOR 5 DAYS
6. TAB. DYTOR 20 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. METOZ 2.5 MG ONCE DAILY AT 2PM TO CONTINUE.
8. TAB. CALCI-CZ **ONCE IN A DAY AT 2 PM** TO CONTINUE.
9. TAB. MULTI-8 ONCE DAILY AT 2PM TO CONTINUE.
10. TAB. UBILIFE ONCE DAILY AT 2PM TO CONTINUE.



REVIEW AFTER 5 DAYS IN NEPHROLOGY OPD

ARH1.0001233014

		<b>Name</b>	Mr. RAJESWAR RAO ALLADI	
<b>Patient Identifier</b>	ARHIP56506	<b>Age</b>	75Yr 0Mth 2Days	
<b>Sex</b>	Male	<b>Date of Admission</b>	06-Jul-2022	
<b>Date of Discharge</b>				
<b>MLC No</b>				
<b>Address</b>	SHAKALLA, BUGGARAM, JAGITIAL,Karimnagar,Telangana		<b>Ward/ Bed No</b>	First Floor, MICU, Bed no:MIC U 10
<b>Primary Consultant</b>	DR. SRI KARAN UDDESH --INTERNAL MEDICINE			

SEPSIS WITH MODS

? TOXIC MEGACOLON

C/o shortness of breath since 2 days  
Vomitings and loose since 3 days

Known case of hypertension,  
Known case of pulmonary TB 6 years back recovered

AT ADMISSION:

Afebrile

PR: 129/min

BP: 110/70mmHg

RS: b/l air entry+, crepts+

CVS: S1S2

RR: 30/min

SPO2: 98% on 6 Litr of O2

P/A: Soft

A 75 years old male patient Mr. RAJESWAR RAO ALLADI came with above mentioned complaints, patient's saturation was low, started on oxygen support, patient was started on broad spectrum antibiotics with INJ. MEROPENEM and INJ. TEICoplanin according to creatinine clearance patient had acute kidney injury with oliguria, so nephrology consultation was taken and SLED was initiated. As patient had abdominal tenderness an ultrasound abdomen was done revealed ? paralytic ileus hence a CT abdomen was done revealed. Colitis involving rectum and proximal sigmoid colon with grossly distended sigmoid colon ---? Toxic Megacolon. General Surgeon consultation was taken and attenders were explained about the need for surgery but the attenders are unwilling hence patient is being discharged against medical advice.

ARH1.00012327  
27

Name

Mr.  
MACHA  
SRINIVAS

Patient  
Identifier

ARHIP56399

Age

45Yr 0Mth 9Days

Sex

Male

Date of  
Admission

29-Jun-2022

Date of  
Discharge

MLC No

Address

utoor,manakondur,Karimnagar,Tel  
angana

Ward/Bed No

First Floor, SICU,  
Bed no:SICU 7

Primary  
Consultant

DR. SRI KARAN UDDESH --  
INTERNAL MEDICINE

Consultants

Surgeons

Dr. GOUTHAM ROY (MS(General  
Surgery),Consultant General  
Surgeon)--GENERAL SURGERY

Anesthesiologists

Dr Subba Reddy  
Kuppannagari--  
ANAESTHESIOLOG  
Y

☐ Diagnoses

Diagnosis

[Add  
Diagnosis](#)

ARHIP56399

ARH1.000123272

☐ Surgery / Procedures  
Done

Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
LAPAROTOMY PLUS SMALL BOWEL RESECTION AND ANASTOMOSIS				

SEPSIS WITH MODS

ACUTE INTESTINAL OBSTRUCTION SECONDARY TO CA. SIGMOID COLON.  
SURGERY - EXPLORATIVE LAPAROTOMY + TRANSVERSE END COLOSTOMY + RESECTING AND  
SIGMOID COLECTOMY WITH HARTMAN'S PROCEDURE DONE ON 20/6/2022.

SMALL BOWEL PERFORATION

SMALL BOWEL RESECTION AND ANASTOMOSIS

C/o pain abdomen  
Mild shortness of breath  
Productive cough

AT ADMISSION:

Febrile-101 F

PR: 92/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 95% on room air

P/A: Soft

A 45 years old male patient Mr. MACHA SRINIVAS came with above mentioned complaints, patient had undergone a colostomy, as the patient had acute intestinal obstruction secondary to suspected cancer of the sigmoid colon. Patient had sepsis with multiorgan dysfunction patient was started on broad spectrum antibiotics IV fluids and nebulization. Patient improved over the next 3 days of hospitalization. Patient developed faecal fistula with bleeding from abdominal wound site. General Surgeon consultation was taken on evaluation it showed small bowel perforation, patient underwent small bowel resection + jejunojejunal anastomosis + ileo-ileal anastomosis. The patient was on mechanical ventilator, patient was requiring inotropic support, post surgery patient was again started on INJ. MEROPENEM and INJ. LINEZOLID patient was weaned off mechanical ventilation inotropic support, now the

patient is requiring 2 Ltrs of oxygen/min and he is clinically better. He needs further treatment but the attenders are unwilling so the patient is being discharged at request.

ARH1.0001232932

**Name**

Mr.  
VENKATASWAMY  
MADISHETTI

**Patient Identifier**

ARHIP56489

**Age**

64Yr 0Mth  
4Days

**Sex**

Male

**Date of  
Admission**

04-Jul-  
2022

**Date of Discharge  
MLC No**

**Address**

209 KAPU  
WADA,Karimnagar,Telangana

**Ward/Bed No**

First  
Floor,  
CICU ,  
Bed  
no:CICU1  
2

**Primary Consultant**

Dr. Vidya Sagar A

CORONARY ARTERY DISEASE, ACUTE IWMI

MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%, SR

CORONARY ANGIOGRAM DONE ON 05/07/2022 - CAD-DVD (LAD, RCA)

PRIMARY PTCA+DES TO LAD WITH METAFOR 3.5 X 32 MM, RCA WITH METAFOR 3.0 X 48 MM  
DONE ON 05/07/2022

R/F: HTN

C/o sudden left sided chest pain a/w multiple episodes of vomitings

AT ADMISSION:

Afebrile

PR: 86/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 64 years old male patient Mr. VENKATASWAMY MADISHETTI came with c/o sudden left sided chest pain a/w multiple episodes of vomitings. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%, SR, CORONARY ANGIOGRAM DONE ON 05/07/2022 - CAD-DVD (LAD, RCA), PRIMARY PTCA+DES TO LAD WITH METAFOR 3.5 X 32 MM, RCA WITH METAFOR 3.0 X 48 MM DONE ON 05/07/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. CILODOC 50MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 4) TAB. STORVAS 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. LNBLOC 10 MG ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.



--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001232937

**Name**

Mr. YAMSANI  
GANGADHAR

**Patient Identifier**

ARHIP56495

**Age**

69Yr  
0Mth  
3Days

**Sex**

Male

**Date of Admission**

05-Jul-  
2022

**Date of Discharge**

**MLC No**

**Address**

PURANIPET  
JAGITAL ,Karimnagar,Telangana

**Ward/Bed No**

First  
Floor,  
CICU ,  
Bed  
no:CICU  
8

**Primary Consultant**

Dr. Vidya Sagar A--

CORONARY ARTERY DISEASE , ACUTE AWTMI

SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%

MODERATE MR, SR

S/P CORONARY ANGIOGRAM DONE ON 06/07/2022 - CAD-TVD [LAD, RAMUS, RCA]

PLAN MEDICAL MANAGEMENT.

R/F: HTN, T2DM

C/o shortness of breath on exertion and fever since 3-4 days

At Admission

Afebrile

PR: 82/min

BP: 120/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-96%

A 69 years old male patient Mr. YAMSANI GANGADHAR came with c/o shortness of breath on exertion and fever since 3-4 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , ACUTE AWMi. Patient was treated with antiplatelets, antianginal, antihypertensive and anticoagulant medication. Coronary angiogram was done on 03/07/22 showing CAD -TVD [LAD, RAMUS, RCA] advised CABG. In view of CAD-TVD+ severe LV dysfunction, moderate MR, Age risk and poor prognosis involved in surgery CABG referred by CT Surgeon and advised medical management. Patient is being discharged in haemodynamically stable condition with medical management advice

#### DISCHARGE MEDICATION:

-----

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPITAB 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. CARDIVAS 3.125 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. INJ HUMAN INSULATARD S/C 8 Units AT 8AM AND 8PM CONTINUE
6. TAB. RECLIDE MR 30 MG ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. DYTOR PLUS 10 MG ½ TAB ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS IN CARDIAC OPD

ARH1.0001041546

	<b>Name</b>	Mr. POSAIAH BERA	~~~~~ ~
<b>Patient Identifier</b>	ARHIP56497	<b>Age</b>	79Yr 1Mth 6Days
<b>Sex</b>	Male	<b>Date of Admission</b>	05-Jul-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	3-5/5 BUDHAKHUD BELLAMPALLI,Adilabad(Adilabad),Andhra Pradesh		<b>Ward/ Bed No</b>
<b>Primary Consultant</b>	Dr Chandra Shekar Sathineni		First Floor, MICU, Bed no:MIC U 11

UPPER GI BLEED  
APD

C/o blood vomitings 2-3 episodes, bilateral pedal oedema

Known case of hypertension, diabetic mellitus  
S/P AVR in 2006

AT ADMISSION:

Afebrile

PR: 70/min

BP: 100/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 79 years old male patient Mr. POSAIAH BERA came with c/o blood vomitings 2-3 episodes, bilateral pedal oedema. Known case of hypertension, diabetic mellitus, S/P AVR in 2006. All necessary investigations were done and diagnosed as UPPER GI BLEED, APD. Managed conservatively. 4 units PCV, 4 units FFP transfusions done. Endoscopy done showed small antral ulcer, no active UGI bleed.

Cardiologist consultation taken and advice followed. Patient attendants requested for discharge, hence patient is being discharge at request.

DISCHARGE MEDICATION:

-----

1. TAB. PANTOCID-L ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.
2. TAB. GEROZ-LP ONCE DAILY AT 2PM FOR 15 DAYS
3. TAB. HEADNEURON ONCE DAILY AT 2PM FOR 10 DAYS
4. TAB. ACITROM 2 MG ONCE DAILY AT 4PM TO CONTINUE
5. TAB. DAPARYL 10 MG ONCE DAILY AT 2PM FOR 15 DAYS
6. TAB. LANOXIN 0.25 MG ½ TAB ONCE DAILY AT 8AM TO CONTINUE 5/7
7. TAB. CARDIVAS 3.125 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE
8. TAB. CARDACE 1.25 MG ONCE DAILY AT 8AM TO CONTINUE
9. TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE
10. TAB. ECOSPRIN AV 75/10 MG ONCE DAILY AT 8PM TO CONTINUE

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

REVIEW AFTER 7 DAYS IN CARDIOLOGY OPD WITH PT/INR REPORT

ARH1.0001232795

**Name**

Ms. BHVATHI  
VIJAYALAKSHI

**Patient Identifier** ARHIP56434

**Age** 52Yr  
0Mth  
8Days

**Sex** Female

**Date of Admission** 01-Jul-2022

**Date of Discharge**  
**MLC No**

**Address** 16-9-68,  
RAMAGUNDAM,PEDDAPALLI,Telangana

**Ward/ Bed No** First Floor, CT POST, Bed no:CT 5

**Primary Consultant** Dr SOMASHEKAR  
K(MS,MCH(CTVS),Consultant-Cardio  
Thoracic & Vascular Surgeon)--C T  
SURGERY

CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + SEVERE LV  
DYSFUNCTION+DM+HTN+ S/P IWMI, IW [SCAR]

SURGERY - CORONARY ARTERY BYPASS GRAFTING [SVG TO LAD, OM] DONE  
ON 05/07/2022.

C/o retrosternal chest pain a/w sweating since 3 days

K/c/o T2DM, HTN

ON ADMISSION VITAL

-----

Patient conscious, coherent

Afebrile

PR-80/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 52 years old female patient BHVATHI VIJAYALAKSHI presented to hospital with c/o retrosternal chest pain a/w sweating since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + SEVERE LV DYSFUNCTION+DM+HTN+ S/P IWMI, IW [SCAR], SURGERY - CORONARY ARTERY BYPASS GRAFTING [SVG TO LAD, OM] DONE ON 05/07/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, SEVERE LV DYSFUNCTION, NO PE/CLOT/VEG, EF-30%

BMI is 26.4 kg/m<sup>2</sup>.

Sr. Creatinine report on 05.07.2022 0.9 mg/dl.

#### DISCHARGE MEDICATION:

-----

- 1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. ND-VIT ONCE DAILY AT 2PM TO CONTINUE.
- 4) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. CALPOL 500 MG THRICE DAILY AT 8AM 2PM 8PM FOR 5 DAYS
- 6) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.
- 7) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.
- 8) TAB. ALPRAX 0.25 MG ONCE DAILY AT 8PM TO CONTINUE.
- 9) TO CONTINUE DIABETIC OWN MEDICATION.

REVIEW AFTER 11 DAYS TO CTVS OPD WITH FBS, PLBS REPORTS



ARH1.0001230922

**Name**

Mr. BANDI  
PARSHURAM .

**Patient  
Identifier**

ARHIP56480

**Age**

40Yr  
1Mth  
24Days

**Sex**

Male

**Date of  
Admission**

04-Jul-  
2022

**Date of  
Discharge  
MLC No**

**Address**

MADDIKUNTA,  
MANAKONDUR,,Karimnagar,Telangana

**Ward/  
Bed No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:116  
B

**Primary  
Consultant**

Dr. SURESH GOUD S(

RIGHT PROXIMAL URETERIC CALCULUS  
SURGERY : RIGHT PUSH BACK PCNL AND DJ STENTING DONE ON 05.07.2022

C/o right loin pain, burning micturition since 5 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 110/70 mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

All required investigations done and enclosed

A 40 yrs old male patient Mr. BANDI PARSHURAM came to the hospital with c/o right loin pain, burning micturition since 5 days. All necessary investigations done and diagnosed as RIGHT PROXIMAL URETERIC CALCULUS, SURGERY : RIGHT PUSH BACK PCNL AND DJ STENTING DONE ON 05.07.2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice. Patient explained for stent removal after 3 weeks.

DISCHARGE MEDICATION:

-----

1. TAB: CEFRON 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: PAN-D 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: A TO Z -NS ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO UROLOGY OPD, STENT REMOVAL AFTER 3 WEEKS

ARH1.0001232858		<b>Name</b>	Mr. CHAWLA MANOHAR
<b>Patient Identifier</b>	ARHIP56455	<b>Age</b>	62Yr 1Mth 26Days
<b>Sex</b>	Male	<b>Date of Admission</b>	02-Jul-2022
<b>Date of Discharge</b>			
<b>MLC No</b>			
<b>Address</b>	3-3-99, PATEL ROAD, KORATLA,Karimnagar,Telanga na	<b>Ward/Bed No</b>	Second Floor, Semi Private, Bed no:117 B
<b>Primary Consultant</b>	Dr. Iftekarali (MS (Orthopaedics),Consultant	<b>Consultants</b>	

**Surgeons**

Orthopaedic Surgeon)--  
ORTHOPAEDICS

Dr. Iftekarali (MS  
(Orthopaedics),Consultant  
Orthopaedic Surgeon)--  
ORTHOPAEDICS

**Anesthesiologists**

Dr Subba Reddy  
Kuppannagari--  
ANAESTHESIOLOGY

☐ Diagnoses

**Diagnosis**

[Add  
Diagnosis](#)

ARHIP56455	ARH1.000123285
------------	----------------

☐ Surgery / Procedures  
Done

**Surgery / Procedure**

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
ORIF DISTAL TIBIA LOCKING PLATE LT				

CLOSED COMMUNITTED FRACTURE DISTAL TIBIA LEFT

SURGERY: ORIF WITH DISTAL TIBIA LOCKING PLATE LEFT DONE ON 05/07/2022

Alleged to have sustained injury due to slip and fall at home, sustained injury to left leg

#### PHYSICAL EXAMINATION:

##### ON ADMISSION

-----  
afebrile  
PR-82/min  
BP-140/90mmhg  
RR-20/min  
RS-BAE+  
CVS-S1S2+  
P/A-Soft  
SPO2-98%

A 62 years old male patient Mr. CHAWLA MANOHAR came with alleged to have sustained injury due to slip and fall at home, sustained injury to left leg. All necessary investigations were done and diagnosed as CLOSED COMMUNITTED FRACTURE DISTAL TIBIA LEFT, SURGERY: ORIF WITH DISTAL TIBIA LOCKING PLATE LEFT DONE ON 05/07/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence she is being discharged with required medication and advice.

#### DISCHARGE MEDICATION:

- 
1. TAB. TROUFIZ 500MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
  2. TAB. VOVERAN SR TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
  3. TAB. KYLID-RD ONCE DAILY AT 8AM FOR 10 DAYS.
  4. TAB. OSTOCAL ONCE DAILY AT 2PM FOR 10 DAYS.
  5. TAB. DISENCHAR TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS.

REVIEW AFTER 10 DAYS TO DR. IFTEKARALI SIR OPD.

ARH1.0001143768

**Name**

Mr.  
VODNALA  
SATHAIAH

**Patient Identifier**

ARHIP56496

**Age**

56Yr  
0Mth  
4Days

**Sex**

Male

**Date of Admission**

05-Jul-2022

**Date of Discharge**  
**MLC No**

**Address**

3-  
146,MUJAMPALY,MANKONDOOR,,Karimnagar,Telangana

**Ward/Bed No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:119  
B

**Primary Consultant**

Dr. SUMALATHA V--PULMONOLOGY

COPD WITH COR PULMONALE

C/o shortness of breath associated with cough and sputum

AT ADMISSION:

Afebrile

PR: 96/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98% with room air

P/A: Soft

A 56 years old male patient Mr. VODNALA SATHAIAH came with c/o shortness of breath associated with cough and sputum. All necessary investigations were done and diagnosed as COPD WITH COR PULMONALE. Managed conservatively. Psychiatric consultation taken and advice followed. Managed conservatively. Patient attendants requested for discharge, hence patient is being discharge at request.

DISCHARGE MEDICATION:

-----

1. NEBULISATION WITH DUOLIN 6<sup>th</sup> hrly FOR 5 DAYS  
NEBULISATION WITH BUDECORT 0.5 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS  
NEBULISATION WITH GLYCOHEAL 25 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS THEN
2. GLYCOHALE-FB TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS AND STOP
3. LUPIHALER
4. TAB. PAH 20MG ONCE DAILY AT 8 AM FOR 10 DAYS.
5. TAB. IVEPRED 4 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS THEN
6. TAB. IVEPRED 4 MG ONCE DAILY AT 8AM FOR 5 DAYS THEN STOP
7. TAB. CLAVUM 625 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
8. TAB. PANTOCID 40MG ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.
9. TAB. ABIPHYLLINE 100 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
10. SYP. ASCORYL-LS 10 ml THRICE DAILY AT 8AM, 2PM AND 8PM
11. TAB. MUCINAC 600 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

REVIEW AFTER 7 DAYS IN PULMONOLOGIST OPD

ARH1.0001222877

**Name**

Mr. K  
LAXMINARAYAN  
A

**Patient Identifier** ARHIP56532

**Age** 62Yr  
8Mth  
21Days

**Sex** Male

**Date of Admission** 08-Jul-2022

**Date of Discharge**  
**MLC No**

**Address** KOTHUR,  
DHARMARAM,Karimnagar,Telangana

**Ward/ Bed No** Second  
Floor,  
Semi Private  
, Bed  
no:105  
B

**Primary Consultant** Dr Chandra Shekar Sathineni

ACUTE GASTROENTERITIS  
DYSELECTROLYTAEMIA

C/o abdomen pain on and off (lower abdominal region) since 1 day

Known case of hypertension on medication

AT ADMISSION:

Afebrile

PR: 100/min

BP: 110/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft





A 62 years old male patient Mr. K LAXMINARAYANA came with c/o abdomen pain on and off (lower abdominal region) since 1 day. All necessary investigations were done and diagnosed as ACUTE GASTROENTERITIS, DYSELECTROLYTAEMIA. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-----

- 1) TAB. RAZO-D ONCE DAILY AT 8AM FOR 10 DAYS
- 2) TAB. HEADNEURON ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001232912

**Name**

Mr. U  
VEERAAIAH

**Patient Identifier** ARHIP56500

**Age** 36Yr  
0Mth  
5Days

**Sex** Male

**Date of Admission** 05-Jul-2022

**Date of Discharge**  
**MLC No**

**Address** RAMAKRISHNA PUR MANDAMARRI  
MANCHERIYAL,Adilabad(Adilabad),Telangana

**Ward/ Bed No** Second Floor,  
Semi Private , Bed no:123 C

**Primary Consultant** DR. SUBRAT KUMAR SOREN

L4-L5 LUMBAR CANAL STENOSIS

SURGERY: L4 LAMINECTOMY & MICRODISCECTOMY DONE ON 06/07/22

C/o low backache since 3 years,  
Pain intensity increased since 3 months  
Tingling and numbness of lower limbs

PHYSICAL EXAMINATION:

ON ADMISSION

-----  
afebrile  
PR-82/min  
BP-130/90mmhg  
RR-20/min  
RS-BAE+  
CVS-S1S2+  
P/A-Soft  
SPO2-98%

A 36 years old male patient Mr. U VEERAAIAH came with c/o low backache since 3 years, pain intensity increased since 3 months, tingling and numbness of lower limbs. All necessary investigations were done and diagnosed as L4-L5 LUMBAR CANAL STENOSIS, SURGERY: L4 LAMINECTOMY & MICRODISCECTOMY DONE ON 06/07/22. Findings: Tight dural sac, disc protrusion. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence she is being discharged with required medication and advice.

#### DISCHARGE MEDICATION:

- 
1. TAB. AUGMENTIN 625 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS.
  2. TAB. GABANTIP AT 100/10 ONCE DAILY AT 8PM FOR 10 DAYS.
  3. TAB. TOLIRITAS-D TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.
  4. TAB. ND-Q10 ONCE DAILY AT 2PM FOR 10 DAYS.
  5. TAB. ND-K2 ONCE DAILY AT 2PM FOR 10 DAYS.

REVIEW AFTER 7 DAYS IN NEUROSURGERY OPD

ARH1.0001226279	<b>Name</b>	Mr. A.V. RAMANA REDDY
<b>Patient Identifier</b>	ARHIP56521	<b>Age</b> 69Yr 9Mth 3Days
<b>Sex</b>	Male	<b>Date of Admission</b> 07-Jul-2022
<b>Date of Discharge</b>		
<b>MLC No</b>		
<b>Address</b>	7-3-160 : DHARMAPURI ROAD JAGTIAL 9440036031,Telangana	<b>Ward/Bed No</b> Second Floor, Semi Private, Bed no:116 A
<b>Primary Consultant</b>	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)-- GENERAL SURGERY	<b>Consultants</b>
<b>Surgeons</b>	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)-- GENERAL SURGERY	<b>Anesthesiologists</b> Dr Subba Reddy Kuppannagari-- ANAESTHESIOLOGY

Diagnosis

S

Diagnosis

[Add](#)  
[Diagnosis](#)

ARHIP56521	ARH1.000122627
------------	----------------

Surgery / Procedures

Done

Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
RIGHT HERNIA (INGUINAL) WITH MESH				

RIGHT INGUINAL INDIRECT HERNIA

SURGERY : OPEN RIGHT INGUINAL HERNIOPLASTY DONE ON 08.07.2022

C/o swelling in right inguinal region

PHYSICAL EXAMINATION:

ON ADMISSION

-----

Pt c/c/c

afebrile

PR-80/min

BP-120/80mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 69 yr old male patient Mr. A.V. RAMANA REDDY came with c/o swelling in right inguinal region. All necessary investigations done and diagnosed as RIGHT INGUINAL INDIRECT HERNIA, SURGERY : OPEN RIGHT INGUINAL HERNIOPLASTY DONE ON 08.07.2022. Findings: Long studing indirect sac noted. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

1. TAB: ROXSAFE 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.

2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. TAB: FAMOCID 40 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 15 DAYS.
5. SYP. LACTIFIBER 3 TSP ONCE IN A DAY AT 8 PM

Review after 10 days in General Surgery OPD.

ARH1.0001232670

**Name**

Mr. HANMANDLU  
KONDURI

**Patient  
Identifier**

ARHIP56386

**Age**

60Yr  
0Mth  
11Day  
s

**Sex**

Male

**Date of  
Admission**

28-Jun-  
2022

**Date of  
Discharge  
MLC No**

**Address**

KODIMIAL,  
JAGITIAL,Karimnagar,Telangana

**Ward/  
Bed No**

Second  
Floor,  
Semi  
Private  
, Bed  
no:105  
A

**Primary  
Consultant**

DR. SRI KARAN UDDESH --INTERNAL

UPPER GI BLEED  
SEPSIS WITH MODS  
AO CKD

C/o unresponsiveness state  
Decreased food intake since few days

Known case of hypertension, diabetes mellitus  
S/P CABG

AT ADMISSION:

Febrile, not responding to commands

PR: 74/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 95% on room air

P/A: Soft



A 60 years old male Mr. HANMANDLU KONDURI came with above mentioned complaints. On examination the patient's capillary blood glucose levels were low so patient was treated with 25% DEXTROSE. Patient was diagnosed as neuroglycopenia and sepsis secondary to probable UTI . Patient was started on broad spectrum antibiotics, the patient had AKI which was non-oliguric. RFT was monitored along with electrolytes. Blood culture and urine culture sent, both was sterile. The patient's clinical condition improved over the course of hospitalization, nephrology opinion was taken and advice followed. A workup for CKD was done and the patient was diagnosed with acute onset chronic kidney disease. On 04/07/2022 morning patient had an episode of haematemesis. 2 units FFP, 3 units PRBC transfusion given. Patient was sent for UGI scopy it revealed multiple duodenal and linear ulcers in the antrum, patient was underwent sclerotherapy. After 24 hours of sclerotherapy the patient still had haematemesis, so gastroenterologist opinion was taken again and patient underwent APC. The patient requires Gastroenterology Care and he is being referred to a Gastroenterologist centre.

DISCHARGE MEDICATION:

-----

1. TAB. SEVLAMER 400 MG **THRICE IN A DAY AT 8 AM 2 PM 8 PM** FOR 7 DAYS
2. TAB. FEBUGET 40 MG **ONCE IN A DAY AT 2 PM** FOR 7 DAYS
3. TAB. SHELCAL-D **ONCE IN A DAY AT 2 PM** FOR 7 DAYS
4. TAB. DAPARYL 10 MG **ONCE IN A DAY AT 2 PM** FOR 7 DAYS
5. TAB. NODOSIS 500 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS
6. SYP. LACTIFIBER 3 TSP ONCE IN A DAY AT 8 PM

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001233080

		<b>Name</b>	Mrs. RAYAMALLAMMA AMUULA	
<b>Patient Identifier</b>	ARHIP56525	<b>Age</b>	63Yr 0Mth 2Days	
<b>Sex</b>	Female	<b>Date of Admission</b>	07-Jul-2022	
<b>Date of Discharge</b>				
<b>MLC No</b>				
<b>Address</b>	BELLAMPALLI,Adilabad(Adilabad),Telangana		<b>Ward/Bed No</b>	Second Floor, Semi Private, Bed no:120A
<b>Primary Consultant</b>	DR. SRI KARAN UDDESH --			

OBSTRUCTIVE SLEEP APNOEA  
MORBID OBESITY  
AO CKD  
PROBABLE HEART FAILURE WITH PRESERVED EJECTION FRACTION

C/o bilateral pedal edema

AT ADMISSION:

Afebrile

PR: 84/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 94% on room air

P/A: Soft

A 63 years old female Mrs. RAYAMALLAMMA AMUULA came with above mentioned complaints, patient was suspected to have obstructive sleep apnoea, so patient underwent polysomnography in which an apnoea hypopnoea index was 30, so now patient has been diagnosed with OSA and has been advised CPAP at night for 4 hours. Patient presented with bilateral pedal oedema and dyspnoea on exertion, so workup for ruling out kidney disease and heart failure was done. Renal profile revealed creatinine of 1.3 and a workup for CKD was done and patient was diagnosed to have CKD. 2D echo was normal. Now the patient is clinically better, hence being discharged with the following advice.

DISCHARGE MEDICATION:

-----

1. TAB. DYTOR PLUS 10/50 **ONCE IN A DAY AT 8 AM** FOR 1 MONTH
2. TAB. SHELICAL-D **ONCE IN A DAY AT 2 PM** FOR 1 MONTH
3. TAB. GABAPIN-NT **ONCE IN A DAY AT 8 PM** FOR 1 MONTH
4. SYP. LACTIFIBER 3 TSP ONCE IN A DAY AT 8 PM
5. CPAP AT NIGHT FOR 6 hrs

REVIEW AFTER 4 WEEKS IN GENERAL MEDICINE OPD WITH RP-II REPORTS

ARH1.0001232517

**Name**

Mrs.  
SINGADASARI  
BHAGYA  
LAXMI

**Patient Identifier**

ARHIP56460

**Age**

41Yr  
0Mth  
15Day  
s

**Sex**

Female

**Date of  
Admission**

02-Jul-  
2022

**Date of Discharge  
MLC No**

**Address**

SARVAREDDYPALLI,GANGADHARA,Karimnagar,Telang  
ana

**Ward/Bed  
No**

Second  
Floor,  
Female  
Genera  
l Ward,  
Bed  
no:GW  
3

**Primary Consultant**

Dr. SURESH GOUD

RIGHT STAGHORN CALCULUS

SURGERY: RIGHT ANATROPHIC PYELOLITHOTOMY DONE ON 05/07/2022

C/o right and left flank pain since 1 week.

ON ADMISSION

-----

Patient c/c

Afebrile

PR-82/min

BP-100/60mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft

SPO2-99%

A 41 years old female patient Mrs. SINGADASARI BHAGYA LAXMI presented to hospital with c/o right and left flank pain since 1 week. All necessary investigations were done and diagnosed as RIGHT STAGHORN CALCULUS, SURGERY: ANATROPHIC PYEOLITHOTOMY RIGHT DONE ON 05/07/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

-----

1. TAB: CIFRAN 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: FAMOCID 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: A TO Z ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO UROLOGY OPD.

ARH1.0001233032

**Name**

Mr.  
RAJIAH  
AKULA

**Patient Identifier**

ARHIP56513

**Age** 65Yr 2Mth  
3Days

**Sex**

Male

**Date of Admission** 06-Jul-2022

**Date of Discharge**  
**MLC No**

**Address**

2-123,  
MALLAPOOR,Karimnagar,Telangana

**Ward/Bed No** First Floor,  
RECOVERY  
ROOM, Bed  
no:RR 4

**Primary Consultant**

Dr. SURESH GOUD S(MS,M.Ch Urology

LEFT PROXIMAL URETERIC CALCULUS  
PLAN : LEFT PUSH BACK PCNL AND DJ STENTING, SURGERY ABANDONED

C/o left loin pain, burning micturition since 10 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

All required investigations done and enclosed

A 65 yrs old male patient Mr. RAJIAH AKULA came to the hospital with c/o left loin pain, burning micturition since 10 days. All necessary investigations done and diagnosed as LEFT PROXIMAL URETERIC CALCULUS, patient plan for LEFT PUSH BACK PCNL AND DJ STENTING but surgery was abandoned. Patient discharged in haemodynamically stable condition proper medication and advice.

#### DISCHARGE MEDICATION:

-----

1. TAB: CIFRAN 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: PAN-D ONCE DAILY AT 7AM BBF FOR 10 DAYS.
4. TAB: A TO Z GOLD ONCE DAILY AT 2PM FOR 10 DAYS